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HEALTH FINANCING

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

ON

HEALTH PLANNING PROGRAM AND CAPITAL POLICY
MAY 3, 1985

MEDICAID COMMUNITY CARE WAIVER
JUNE 25, 1985

DEFICIT REDUCTION PROPOSALS: PART B OF MEDICARE—H.R. 2293,
H.R. 2864, H.R. 2342, H.R. 2807 AND H.R. 2703
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HEALTH PLANNING PROGRAM AND CAPITAL POLICY

FRIDAY MAY 3, 1985

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to call at 10 a.m. in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will please come to order. The Subcommittee on Health and the Environment is meeting today to receive testimony on the Health Planning Program and its relationship to capital policy. We have an impressive group of witnesses who have a wide range of perspectives about the issues before us.

The debate over how to reauthorize the health planning program has continued for several years without resolution. I believe our failure to agree on the future of health planning is not surprising in light of the controversial job Congress gave to health planning. Saying no to hospitals, nursing homes and other health care facilities which want to expand or telling a provider that some people don't have access evokes strong emotions on all sides.

While we haven't agreed on the long-term purpose and functions of health planning, I believe there is a consensus that there must be limits on the growth of health care facilities and services and there must be better access. We can't afford to duplicate expensive new technologies when we are faced with administration pressure to increase premiums and copayments for Medicare beneficiaries and to freeze provider payments. We can't afford unnecessary hospitals beds in a community when the Census Bureau tells us there are 35 million Americans without health insurance.

The Congress understands this dilemma and has voted to limit the growth of hospital capital expenditures.

In 1983, when enacting the current DRG reimbursement system, Congress established October 1, 1986, as the date when capital expenditure review would become mandatory in order for hospitals to receive medicare payment. This new requirement will go into effect unless Congress changes the current retrospective cost reimbursement for hospitals.

States are equally concerned about restricting the growth and cost of hospitals, nursing homes and other facilities. During the last couple of years, almost half the States have established mora-

toria on some types of new building through their their certificate of need laws.

Changes in Medicare reimbursement for capital expenditures will have a major impact on hospital capacity and how States attempt to control it through their own Medicaid and certificate of need laws. I believe our decision on Medicare should be coordinated with our final resolution of how health planning and certificate of need programs function and what they should cover. I hope other members will join me in supporting legislation to maintain the stability of our health planning program for at least 1 more year until we can make these broader decisions about Medicare.

Our first panel consists of John A. Taft, Jr., president, Delnor Hospital, St. Charles, IL; Joseph E. Sandlin, president, Southern National Corp., Southern National Bank; LaRah Payne, director of planning, Howard University Hospital, Washington DC, and Anthony Watson, president, American Health Planning Association, executive director.

If the four witnesses will come forward at the present time to the table, we would appreciate it.

We want to welcome you to our subcommittee meeting today. I understand Anthony Watson isn't here. I might ask David Helms, president-elect of the American Health Planning Association, to come forward if he would and take his place.

Your full statement will appear in the record. We would request that you keep your summary to no more than 5 minutes, because we are on a tight schedule today, and we want full opportunity for questions and answers, and an opportunity to hear all the other witnesses. We are going to be using—I hate to do it, an alarm clock.

After 5 minutes when the bell rings, we will have to ask you to stop, and the testimony in the record will be the full testimony that you have given to us. Let's start with Mr. Sandlin if he might.

STATEMENTS OF JOSEPH E. SANDLIN, PRESIDENT, SOUTHERN NATIONAL CORP., AND SOUTHERN NATIONAL BANK; JOHN A. TAFT, JR., PRESIDENT, DELNOR HOSPITAL, ST. CHARLES IL.; LaRAH PAYNE, DIRECTOR OF PLANNING, HOWARD UNIVERSITY HOSPITAL (DC); AND DAVID HELMS, PRESIDENT-ELECT, AMERICAN HEALTH PLANNING ASSOCIATION

Mr. SANDLIN. Mr. Chairman, my name is Joseph E. Sandlin, president of Southern National Corp., and Southern National Bank of North Carolina. I am here today to speak in strong support of a continued Federal commitment for State and local health planning.

As a former convenor and president of a health systems agency, I would like to recommend that consideration be given to restructuring of the board of directors of health systems agencies. The present requirements are too rigid and do not allow for the involvement of significant numbers of business, insurers, and purchasers of health care. These groups are necessary to the process if meaningful cost containment is to be achieved.

At the present time, there is a need for a close coordination between health systems agencies and industry in the form of education and health promotion. There is a strong need for educational

programs in industry to discourage smoking, encourage exercise, and detect health problems in their early stages.

Health systems agencies are currently developing wellness programs and disseminating information to our employees which suggest and explains less costly health alternatives. These programs include the encouragement of ambulatory facilities, second opinions by physicians and surgeons, and group health service organizations, such as health maintenance organizations, where needed.

There is strong interest on the part of the industrial complex for methods to contain costs. At the present time the new programs for reimbursement for Medicare and Medicaid expenses are leaving industry in an exposed position as to cost. There should be coordination for controlling medical costs in the private sector.

It should be a part of the health systems agencies program to approach the medical profession for objective help in reducing overall hospital and general medical expenses.

The patient will show interest in such cost containment only when he or she has to pay a portion of the cost and understands the alternatives. It is important that industry be encouraged to join with HSA and assist in the health care cost containment education of the private sector.

Planning is needed now more than ever, and funding for planning is needed now and for years to come. Health planning involves communities in determining health needs in the context of existing health resources; shaping the delivery of health care to promote less costly settings; avoiding unnecessary overbuilding; and purchasing of underused and duplication of medical equipment, and avoiding unnecessary duplication of services; and finding the most efficient ways of meeting the basic health care needs of the economically disadvantaged.

Business is leading the way in health care cost containment, but the cost problem is too big for any one group or sector to solve by itself. Increasingly, the private business sector is teaming up with health planning to provide that mixture of efforts which is critical to changing a health care system as complex as ours. State and local planning agencies are an important and effective part of an integrated approach to solving the cost problem.

Planning agencies can better serve as watchdogs for payors and consumers, making recommendations designed to restrain costly hospital or other health-facility expansion or duplication. They also are a check and balance in a health care system. Business participation in this process is vital and influential.

Health planning elevates awareness and understanding of critical issues; analyzes disparate views; fosters coordinated actions; and addresses issues the marketplace cannot and will not resolve. As the health care system components compete and increasingly work in greater isolation, participatory decisionmaking becomes more critical.

American businesses are taking an active role in seeking to constrain amounts spent for their own employees' health care, while at the same time join together in business coalitions to influence the system providing that care. Yet, American business cannot and should not be expected to solve these problems by itself. Neither can government or health planning by themselves.

Health planning is a valued community resource for allowing us a voice in our future health care planning.

Thank you, sir.

Mr. WAXMAN. Thank you very much, Mr. Sandlin.

Mr. Taft.

STATEMENT OF JOHN A. TAFT, JR.

Mr. TAFT. Mr. Chairman, thank you for the opportunity to present my view on the need for Federal reauthorization of health planning. I am John A. Taft, Jr., president of Delnor Hospital, St. Charles, IL.

I have been the chief executive of this community hospital for 24 years. I serve on the boards of the Illinois Hospital Association and the Chicago Hospital Council. I am also president of the Health Systems Agency for Kane, Lake, and McHenry Counties, a member of the Illinois Statewide Health Coordinating Council, and a strong supporter of community-based health planning.

I urge the continuation of Federal support for health planning now and for the future.

As a hospital executive, I am struggling with all the complexities of our health care system—DRG's, indigent care, market share, multi-institutional arrangements, alternative health care organizations, et cetera. I am, as I should be, focusing on the viability, efficiency and effectiveness of my hospital and its ability to provide needed high quality services.

I am squeezed between regulation and competition, and between need and demand. But health planning as we know it gives me and the community something more—a forum to look at health care needs from a community perspective. At the same time, as hospitals are increasingly forced by payment systems and budgetary realities to place their energy and attention on the needs of their own institutions, the role of planning becomes more vital.

Something must assist us to get outside and look at our immediate problems, and to give us reason to work together to improve the overall health care system in our communities. Something must help offset the fallout of health policy decisions deliberately designed to reduce health care expenditures and the limits of Federal responsibility, creating a full shift downward to our most vulnerable populations. Health planning is that something in my community.

If this is the decade of the accountant, medical record administrator, and marketer in health care, who will watch out for quality, access to care, and peoples' needs on a community basis? Now, more than ever, the system needs surveillance and planning.

Yes, budget makers need help in cost containment and so do consumers. But no one wants to slash costs in ways that damage, perhaps permanently, the fabric of health care or that effectively deprive large numbers of people of the care they genuinely need.

The situation calls for monitoring the effects of change, for objective measurement and reporting, and for strong efforts to preserve the public stake in a lean and more efficient system, but not for denial of appropriate care for the sick.

One reason I strongly support continuation of a Federal commitment to health planning is that it is one of the few remaining Federal commitments to the Nation's health rather than a commitment to budget protection.

Let's look fairly at what Federal health policy has been in recent years. It has had a limited agenda for reducing Federal dollars going to health care. I emphasize Federal dollars—not State, not municipal, not third party payor, and not consumer. This limited commitment has been accomplished by:

First, reducing Medicare outlays through reductions in benefits and payments, increased deductible and coinsurance features, reductions in payments to providers, and increased premium charges to the beneficiary for part B benefits.

Second, reducing Federal dollars to States for Medicaid by reducing the Federal share, reducing covered services, tightening eligibility requirements, and cutting the rates of payment to providers.

Third, reducing Federal outlays by shifting additional costs to States through block grants with reduced funding and by eliminating Federal dollars for some programs altogether; by shifting costs to hospitals, and to a lesser extent, to other providers of services; and by shifting the shortfall to other payers.

Let me now describe what Federal health policy has not been in recent years. It has not been:

First, a concern for access to quality care or for a share of the costs of uncompensated care.

Second, a concern for the equitable allocation of limited resources.

Third, a regard for community need or community input into decisionmaking about the health care system.

Fourth, a concern for total system costs or total system capacity in the long run.

Fifth, a concern for the ramifications of resulting changes in the configuration of the system.

And, finally, a concern for the financial or geographic availability of services.

Health planning is concerned with these critical issues. That is what health planning is about—access, cost containment at all levels, maintaining the viability of community hospitals which provide needed services, and equitable allocation of limited resources.

The proposed elimination of Federal support for health planning is not a budget issue, but rather a philosophical and political issue of who, if anyone, decides the future nature and configuration of the health care system.

I hear much argument about how health planning and certificate of need inhibit the competition needed to attack the health care cost problem. I view the situation differently.

I do not consider health planning and certificate of need to be synonymous.

Health planning is a structured process of open and formal participation at State and community levels to analyze, plan for, and carry out policies to enhance the ability of citizens to obtain access to quality health care at reasonable cost.

Certificate of need is a regulatory tool applied by State governments to control the overall physical size of the health care system and the distribution of its services.

I strongly support health planning and believe the structure of community-based health systems agencies and State health planning and development agencies should be maintained to carry out their critical mission.

I am less happy with certificate of need, but accept the reality that it is needed in the current policy environment and that it can continue to work. In my State, it has saved the public many dollars and has improved the distribution of services. However, I very much support efforts to streamline the process.

I recognize that certificate of need must walk an extremely difficult line between ineffectiveness and over-regulation. I believe that line can be drawn with a Federal commitment to an adequately financed structure of State and community planning agencies.

I am concerned that in the absence of a Federal commitment, States, which also face budget realities, may impose very stringent certificate of need programs focused solely on protecting Medicaid and other State expenditures. Other important functions of health planning—health policy formulations; protection of access and quality; identifying emerging problems; technical assistance; and data analysis—may be eliminated.

In conclusion, health program and funding cuts designed to reduce Federal and State health expenditures combined with efforts to establish stronger market forces in the health care system are creating unprecedented change and uncertainty. Simultaneously, health care costs continue to be a No. 1 health policy dilemma, with conflicting pressures to spend more or spend less, to regulate more or regulate less, or to shift the health care cost problem to others. All of this is occurring at a time when predictable demographic changes, and pressures to expand our technological capacities, are creating new demands and expectations of American health care.

I am concerned about what is going on in health care, just as I am optimistic that we can face the future with wisdom and patience to make the changes necessary to reduce health care expenditures and assure access to care. At this critical juncture, as we strive to put together a force for change, I ask you to reauthorize the very necessary health planning function.

Thank you.

Mr. WAXMAN. Thank you, Mr. Taft.

Mr. Payne.

STATEMENT OF LaRAH PAYNE

Mr. PAYNE. Mr. Chairman, my name is LaRah Payne, and I am the director of planning at Howard University Hospital here in Washington, DC. Thank you for the opportunity to testify before you on the subject of reauthorization of Federal health planning legislation.

The new market-oriented, competitive health care environment has revolutionized the health care industry, making many of the regulatory functions established by Public Law 93-641 redundant or

counterproductive. Therefore, a blanket reauthorization of the existing health planning structure would be inappropriate, potentially hazardous to the public's health, and a serious obstacle to many hospitals' abilities to serve the needy.

Implementation of the fixed price Prospective Payment System (PPS) for Medicare patients has drastically altered health care provider behavior. Medicare reimbursement changes—while not yet perfected—have provided strong incentives to minimize the cost of providing safe and effective health care services and have stimulated increased competition among providers for non-Medicare patients who can pay for services.

In this new marketplace, hospitals must compete to survive. Present health planning regulatory requirements restrict hospitals' ability to respond to market forces and community demands for service. This could range from delays in providing new patient care options to the public which result in lower cost services, to obstacles to terminating services which are no longer needed but still subject to certificate of need regulations.

Many hospitals are finding the present health care planning structure to be a major obstacle in their efforts to ensure access to care to those unable to pay. This is particularly the case for those hospitals which maintain a firm dedication and commitment to ensuring access to care for the indigent. Howard University Hospital is just one of several institutions in the District of Columbia which serves substantial proportions of indigent patients.

The health planning structure impairs hospitals service to the needy in two major ways:

One, many hospitals whose missions include serving the poor could compete successfully for paying patients who would to an extent subsidize uncompensated care, but the regulatory requirements severely constrain those hospitals' ability to compete.

For example, no District of Columbia hospital has yet been able to acquire a Magnetic Resonance Imager—or MRI—because of substantial delays with the local planning agency and its voluminous regulations and procedures.

However, an imager is in service in nearby Bethesda, where it was acquired and installed without any regulatory impediments. Not only are D.C. hospitals unable to compete for patients who are known to need MRI services, but their patients who require imaging services must be transported to outside facilities which profit from their competitive advantages.

Two there have been examples cited by various hospital administrators where delays in granting the hospital's requests for new services resulted in the denial of needed services to needy populations until certain rules and procedures of the planning agency were either created or modified to allow the new service to be established.

Such delays cannot only result in adverse health outcomes to the effected population but can also result in legal action against the hospital. Such adverse legal action will ultimately have the effect of raising the costs of care to the effected community.

One of the priority objectives of Public Law 93-641 as it was being debated by the 93d Congress was hospital cost containment.

Cost containment savings resulting from the implementation of that statute have been and continue to be a debated issue.

Further, these cost containment efforts have actually cost hospitals and other institutional providers of health care services significant dollars in compliance costs and, through cost inflation, caused by delays in development of approved undertakings.

It has recently been shown in the hospital industry that changes in the payment mechanism and a competitive environment can much more quickly bring about changes in the behavior of hospitals, and cause hospitals to be much more responsive to consumer demands for safe, cost effective services.

In conclusion, I wish to note two significant conceptual problems with the current health planning laws: First, the Federal Government—both Congress and the administration—are encouraging competitive behavior by hospitals and other health care providers through the Medicare prospective payment system.

However, the present health planning law remains one of the most anticompetitive forces adversely affecting the delivery of health care services. The health planning structure should not be reauthorized without a major debate by the Congress and the American people as to which strategy, regulation or competition, or which mixture of the two strategies would be preferred.

Resolution of the conflicts created by these two different policy thrusts should be an important priority.

Second, the implementation of the health planning programs throughout the nation have deemphasized planning and stressed regulation. As a result, the benefits of community dialog and research into community service needs have been seriously neglected.

Any extension of health planning laws should include a major redirection of efforts to enhance the early identification of community health needs, and alternative mechanisms to meet those needs: a cardinal priority to promote the health of all the citizens of our pluralistic society.

Thank you.

Mr. WAXMAN. Mr. Helms

STATEMENT OF DAVID HELMS

Mr. HELMS. Thank you. Those of you who know Tony Watson know I am not Anthony Watson. One of the privileges of being a president-elect to an organization is that you get to pinch hit on short notice. I would like to say on behalf of the organization, I am David Helms, president-elect, and executive director of the Alpha Center serving the States and HSA's in the Northeast. In recent years we believe health planning has done its share to move the health system toward more efficiency, stimulating growth of alternative systems and providing technical assistance to a growing number of business coalitions, reducing unnecessary duplication of services.

We have worried about cost containment. But we have also followed our mandate to improve access to care and we have our concerns about quality and the impact of prospective payment.

We hope the debate in Congress will move from this immediate, shortrun focus on the Federal budget, to being concerned about the

total health care system. We believe the Federal Government has a responsibility to assist in balancing the needs of controlling costs while improving access and quality.

We believe health planning is needed now even more to monitor the community impact of reimbursement and health policy changes; to collect and analyze a sound and intelligible data base about local health services on which decisions can be rationally taken; to achieve a working consensus among the interest groups—business, labor, health profession groups, institutions, insurers, and organized consumers—on difficult allocations of resources through the capital expenditure review process.

We believe health planning is needed to provide business coalitions and other groups technical assistance in analyzing data and understanding the health care system, giving them an opportunity to participate in decisionmaking.

I have had a number of business people speak to me recently that they have now discovered the real need for health planning. Now is not the time to take away the technical support these emerging groups are getting. Somebody has to be looking at the community need for health services, even more now that we are moving toward market forces and relying on competition.

I might add if health planning has been standing in the way of competition, a lot has happened in the last few years. We need to act as a primary vehicle for participatory community decisionmaking process.

As the health care system components compete and increasingly work in greater isolation, participatory decisionmaking, looking at the community's needs becomes more essential. We need to assist rural communities which aren't always benefiting from the effects of the procompetitive movement, who are now seeking to preserve and maintain adequate health resources.

We need to provide a public system of accountability for these major capital investment decisions which affect payers and patients for years to come and we need health planning to be the community's watchdog to offset the growing self-interest which goes hand-in-hand with increased market competition.

We urge the subcommittee to extend the current health planning structure for the next several years, as you consider future Federal policies for capital payment, indigent care and access to services. Once these issues are resolved, it may be necessary to restructure the planning process to meet new challenges.

However, for now, the structure works and is the remaining Federal commitment to balancing the need to restrain costs with community need and access to quality services.

We recognize that the health planning program can and should be streamlined. We actively support amending the law to make it more flexible and efficient. We stand ready to work with the committee to make health planning a better program and we are not alone. As you can see from the attached statement in support of health planning reauthorization, many organizations share this view and urge a strong Federal commitment to health planning.

Thank you.

[The prepared statement of American Health Planning Association follows:]

ANTHONY L. WATSON

PRESIDENT

AMERICAN HEALTH PLANNING ASSOCIATION

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

The American Health Planning Association is pleased to have this opportunity to appear before you today to urge the renewal of the health planning program. My name is Anthony L. Watson. I am the President of the American Health Planning Association and Executive Director of the Health Systems Agency of New York City.

Why Authorize Health Planning Now?

Because it is needed now more than it was when Congress passed the Health Planning and Resources Development Act of 1974. The reasons for planning then and now are the same--TO ENSURE ACCESS TO QUALITY CARE AT A REASONABLE COST. But the need for planning is greater now due to the tremendous changes that are taking place in the health care system.

While "budget", "competition", and "cost containment" are the immediate concerns at the federal policy level--they should not and cannot be the only concerns.

Briefly, a few key points:

- o Not all the issues are in Washington. The health care industry across the country is in turmoil, financially

and structurally, as administrators and entrepreneurs, adapting to recent changes in federal policy, try to devise ways of institutional and professional survival or gain.

- o Many critical problems in federal health policy remain unresolved and are in fact magnified by the DRG payment system. Indigent care, the plight of rural and inner city hospitals, access to capital by needed community hospitals, and the ability of teaching hospitals to compete under the DRG system are some of the serious and growing issues which must be resolved.
- o Historically, the hospital industry never has been competitive,--never has followed the market model. Many hospitals serve important educational and research purposes, and provide needed care to the indigent. These functions are negative assets in a competitive situation.
- o The problems of access to care and uncompensated care are intensifying as hospitals act like businesses to compete for market shares of well insured patients, leaving the uninsured and underinsured to those institutions that remain committed to the concept of a hospital as a community service.

- o Theory aside, whether it be regulation or competition the reality is that most observers do not believe the health care system, and in particular the hospital system, is now competitive or can become so for a long time. The two states which have totally deregulated capital expenditure reviews are now seeing massive increases in new hospitals, hospital beds and nursing homes despite existing excess capacity.

In recent years health planning has done its share to move the system towards more efficiency, stimulating the growth of alternative delivery systems, providing technical assistance to the growing number of business coalitions, and reducing unnecessary duplication of resources. Cost conscious productivity has been our response to Washington's concern for reducing federal expenditures. However, we also followed our mandate to improve access to care and we do have a concern for quality.

We hope the debate in Congress too will move on from its immediate and short run focus upon the federal budget to the total health care system perspective. Today's revolutionary changes in the health care system cannot and must not result in less effective, less accessible, or less acceptable health care in our communities.

Health Planning Is Needed to:

- o Monitor the community impact of reimbursement and health policy changes.
- o Collect and analyze a sound and intelligible data base about local health services on which decisions can be rationally taken.
- o Achieve a working consensus among the interest groups--business, labor, health profession groups, institutions, insurers, and organized consumers--on difficult allocations of resources through the capital expenditure review process.
- o Provide business coalitions and other groups technical assistance in analyzing data and understanding the health care system, giving them an opportunity to participate in decision-making.
- o Look at community need for health services now and in the future rather than institutional need.
- o Act as the primary vehicle for participatory community decision-making. As the health care system components compete and increasingly work in greater isolation, participatory decision-making becomes more critical.

- o Assist rural communities seeking to preserve or increase needed health care resources.
- o Provide a public system of accountability for major capital investment decisions which will affect payers and patients for years to come.
- o Be a community watchdog to offset the growing self interest which goes hand in hand with increased competition for market shares.

Mr. Chairman, over the next few years the Congress will be debating the serious and complex problems of federal payments for capital costs, indigent care, and access to service. These are basic systematic problems which led to the need for the development of a health planning process in the 70's and which will only worsen in the absence of such a process.

While Congress considers these issues, allocation decisions will continue to have to be made by the marketplace, by the budgetary process, by health planning or by a mixture of the three. Unplanned and unrestrained alterations and growth in our health care system will cause health care costs to escalate and further skew the distribution of services away from the most needy in our society.

We urge the Subcommittee to extend the current health planning structure for the next several years as you consider future federal policies for capital payment, indigent care, and access to services. Once these are resolved, it may be necessary to restructure the planning process to meet new challenges. However, for now, the structure works and is the remaining federal commitment to balancing the need to restrain costs with community need and access to quality services.

We recognize that the health planning program can and should be streamlined. We actively support amending the law to make it more flexible and efficient. We stand ready to work with the committee to make health planning a better program and we are not alone. As you can see from the attached statement in support of health planning reauthorization, many organizations share this view and urge a strong federal commitment to health planning.

THANK YOU...

April 26, 1985

THE ORGANIZATIONS LISTED BELOW URGE CONGRESS TO ENACT A STREAMLINED,
STABLE, AND EFFECTIVE HEALTH PLANNING REAUTHORIZATION NOW.

The health care system in America is in a state of extreme change, and many policy issues which will affect significantly the size of the system, the cost of health care, the distribution of services, and the access to them have yet to be resolved. These are health planning issues and are of concern and importance to all Americans, be they providers, purchasers, planners, or potential patients.

- ° HEALTH PLANNING MUST BE STABILIZED WITH A REAUTHORIZATION. DISMANTLEMENT OF THE HEALTH PLANNING STRUCTURE IN THIS ERA OF UNCERTAINTY AND FLUX WOULD BE CONTRARY TO THE PUBLIC INTEREST.
- ° THE HEALTH PLANNING PROGRAM SHOULD BE STREAMLINED, MINIMIZING PROCESS REQUIREMENTS AND ALLOWING STATE AND COMMUNITY FLEXIBILITY TO RESPOND TO THE CHANGING HEALTH CARE ENVIRONMENT.
- ° THE HEALTH PLANNING REAUTHORIZATION SHOULD PERMIT VOLUNTARY PARTICIPATION, BY REMOVING LARGE PENALTIES AND ALLOWING STATES TO CHOOSE NOT TO JOIN THE PROGRAM.

AMERICAN ASSOCIATION OF RETIRED PERSONS

AMERICAN HEALTH PLANNING ASSOCIATION

AMERICAN NURSES ASSOCIATION

AMERICAN PUBLIC HEALTH ASSOCIATION

BLUE CROSS AND BLUE SHIELD ASSOCIATION

CATHOLIC HEALTH ASSOCIATION

GROUP HEALTH ASSOCIATION OF AMERICA

HEALTH INSURANCE ASSOCIATION OF AMERICA

NATIONAL ASSOCIATION OF COUNTIES

NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

Mr. WAXMAN. Thank you very much for your testimony.

I have two questions which I want to address to all the members of the panel. I will start with Mr. Sandlin first because I understand you may have to leave a little earlier.

It appears to me that business, labor, insurance companies and many providers believe that there is an important role for health planning and certificate of need programs. Has support for these programs increased?

Mr. SANDLIN. There has been a strong request for support to the HSA's. In recent years the allocations of funds to them has been somewhat less than it was in prior years.

I think there has been a willingness of the staff to work with us. I do not at this particular point think it has reached an efficient point that industry would like to see.

Mr. WAXMAN. What role should health planning agencies play in assuring that people without health insurance are cared for?

Mr. SANDLIN. I am not sure that I am qualified to give you an effective answer, Mr. Chairman. I do not believe that anything has changed in the health planning process that has deprived anyone.

In the areas of southeast North Carolina for which I have reasonable expertise, many rural-based community health facilities have been added jointly by industry members of the boards and by the health planners who are affiliated with the board.

I really feel like that health care has improved in my area. I am somewhat unqualified to answer. I cannot feel that anything that the health service agencies have done that has in any way mitigated their needs or hurt them in any way.

I think it has helped them materially.

Mr. WAXMAN. Let me ask the other members of the panel if any of you want to respond to either of these questions. One, whether you see support for health planning increasing, and, second, what role should health planning agencies play in assuring that people without health insurance are cared for?

Mr. HELMS. Mr. Chairman, as I mentioned, I think business and labor, as they come to grips with the effects of the procompetitive system, are seeing a need to analyze the cost in their community, to see the effects of different programs.

We are seeing the business and labor leaders going to the health systems agencies in increasing numbers, where the data and analytic support exists.

We will acknowledge that that analytic support has been curtailed and is not what we would want it to be ideally due to all of the budget cuts.

Your second point, I think, is really a significant one. The role that health planning plays in ensuring access. I think it is the hallmark of this program in its early days that we did so well to identify problems of access and mobilize support, and brought primary care to rural parts of the country and developed programs in the inner-cities.

A critical role obviously is to identify the needs of the indigent, who is not being served. This is a very difficult problem, to go out into communities and say who is not being served.

But health planning agencies are participating in studies. They are looking at needs. They are working with their hospitals to see who may be not receiving care.

And they perform that very essential role of mobilizing community support to get the labor, the community leaders, the local government leaders, State legislation, if necessary, to try to ameliorate these problems.

Mr. WAXMAN. Mr. Payne.

Mr. PAYNE. Mr. Chairman, I think that the increasing support for health planning programs that has been most beneficial has been in the area of information or data management. Even hospitals—and certainly businesses and business coalitions—are interested in that particular function.

Hospitals are interested in the information these particular agencies can collect and pull together and provide as information to the various health system players in the local communities.

I think that is a noteworthy activity. In terms of the second question: Is there a role for advocacy for persons without insurance. I think planning agencies may have a role to play here in terms of making sure that community members do not get disenfranchised simply because they happen to reside in particular geographic areas of the community.

I think there have been some instances that planning agencies—for instances, in New York City, Tony Watkins' agency—have been innovative in structuring new services by providers that may not reside in a particular geographic area that does not have as many health resources.

But the providers have been able to provide satellite health services in these areas, so that all providers, regardless of where they are, geographically, have a part to play in supporting health care delivery to needy residents.

I think health planning agencies can work to advocate that and facilitate that type of cooperation.

Mr. WAXMAN. Mr. Taft, do you want to comment?

Mr. TAFT. In response to your first question, I feel that the demand for, the recognition of the need for health planning is sustained and has been sustained since Public Law 93-641 came into being and its present predecessor.

As for certificate of need on the regulatory side of it, I see a shift in viewpoints on the part of many who may feel that market forces will help to solve the problems which were initially aimed to be solved by certificate of need.

Recognizing, however, that it is important for access that the facilities be available. Certificate of need perhaps has been more effective in preventing excess where excess cost existed, or did exist, but not necessarily urging and causing to come into being the filling of vacuums where need existed.

As to the second question, I believe that health planning agencies, both at the local and at the State level, have and will continue to provide an important role as advocates of the uninsured or the inadequately insured, because access to quality health care is a basic tenet of planning. And things have been done around the country, and will be in the future, to help.

Mr. WAXMAN. Let me thank each of you for taking the time and making your presentations to us. You have been very helpful to us. We will share your views with the members of the subcommittee, as we fashion legislation to see if we can figure out what to do with the health planning program.

Thank you very much for being with us.

Our next two witnesses will be Jack W. Owen, executive vice president, American Hospital Association, and Linda Lanam, executive Washington representative, Blue Cross and Blue Shield Association.

We are pleased to have you with us today and look forward to your testimony. Again, we will have the prepared statements in the record.

STATEMENTS OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION; AND LINDA L. LANAM, EXECUTIVE WASHINGTON REPRESENTATIVE, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. OWEN. Thank you, Mr. Chairman.

My name is Jack Owen. I am the executive vice president of the American Hospital Association, representing about 6,100 hospitals in our country. I would like to comment about three areas: access, capital, and our position for supporting reauthorization of the planning proposal.

First, on the access question. Whether the objective of health planning is containing health costs or assuring access to care, we feel it should be left to the discretion of leaders within each State to determine whether and what local health planning and State level capital expenditure programs are needed.

In many States various studies and initiatives are underway to address indigent care problems independent of Federal inducements or requirements and independent of State CON mechanisms. Rather than involving itself specifically in a State process, the Federal Government's primary role in assuring access to health service should be to assure adequate and equitable financing of Medicare and Medicaid.

In fact, it is at least in part a response to Federal cutbacks in the Medicaid Program that many State and local access to care initiatives have been undertaken. Moreover, to date Medicare has refused to recognize charity care as a legitimate cost of operations in its payment policies. Assuring various population segments adequate access to care is essentially a health services financing problem and not necessarily a regulatory issue.

On the capital side, under the prospective payment system, acute services are paid on a per case basis. Because there are few decisions that do not have significant operating cost implications, hospitals must scrutinize existing and proposed new technology, services, facilities and equipment to ensure there is or will be sufficient operating revenue to justify their continuation or addition.

PPS forces hospitals to integrate strategic and daily cost management processes. In part, the future need for capital may be addressed directly through the changes in the Medicare payment

system and its underlying assessments that will stimulate the move to regionalization of highly specialized and costly services.

Moreover, even though depreciation, interest and lease costs are currently passed through in the prospective payment system, operating cost increases which result from capital spending are not.

Thus, the medicare payment system reinforces sound planning. Until such time as capital is included in the prospective payment system, we feel the continuation of the planning system deserves to be continued. In light of the incentives for restraint in PPS, we believe there is less need for strict federally mandated capital expenditure regulation, however.

From the hospital's viewpoint, current Federal health planning is too inflexible. The program has been ineffective in large measure because it has tried to impose rigid and arbitrary standards and procedures in situations that are vastly different across the Nation.

As the Government considers specific changes in the Medicare/Medicaid System, it must be highly conscious of the effect of those changes on the hospital industry's overall ability to generate capital.

Even with Medicare's prospective pricing system, over time attempts are made to ratchet down hospital prices. If there are no alternative sources—Medicare beneficiaries and/or other patient payment sources—for meeting resultant short falls, there could be substantial disruption in the hospital capital market.

We took a survey of State hospital associations in October 1984 to find out what was happening in regard to capital expenditure regulations, moratoria on bed/service additions, new construction, capital expenditure, coverage of reductions, conversions of services, et cetera.

In summary, the survey shows that the States in the Northeast appear to be maintaining capital expenditure review programs which are more restrictive than Federal requirements. States in the Midwest and Southeast are more likely to conform and those in the West and Southwest are less restrictive.

Finally, this is based on several points I would like to quickly go through. Consistent with our goal of developing a more competitive health care delivery system, we think that the health planning should support, and we will support an approach consistent with these following principles.

First, eliminating Federal sanctions under which public health service funds are denied to States not in compliance with Federal requirements, so-called sanctions. Including a sunset date in any Federal health planning legislation—we feel that even though planning may be here, there should be a sunset date to look at it because the world is changing out there and it should be looked at every year or so.

Allowing States to participate voluntarily in the Federal program, make it voluntary. Allow States to determine whether local planning units should be formally involved in CON. Establishing a higher CON reviewer threshold, something around \$5 million in the Federal planning law, to encourage more streamlined CON review programs and to insure that States with review thresholds at or below this still remain eligible for Federal funding because we will find there are States with lower limits.

We would like to limit the Federal involvement in local planning to a matching grant program—to encourage locally controlled communitywide planning process, Federal involvement should be limited to making grants directly to the local communitywide area planning organization for implementation.

We feel there should be a local match of 50 percent or more required and no restriction should be placed on the source of the local match except that no single source should contribute more than 25 percent of the total budget.

Those are the positions we would like to see in any continuation. We will support continuation of this for another year.

Thank you.

STATEMENT OF LINDA L. LANAM

Ms. LANAM. I am Linda L. Lanam, executive Washington representative of the Blue Cross and Blue Shield Association, the national coordinating agency for the member Blue Cross and Blue Shield plans.

We appreciate the opportunity to share with you our thoughts on the need for a Federal role in health planning. Our views are based on the knowledge and experience gained by the Blue Cross and Blue Shield organization through a long-standing involvement in community health planning, an involvement which dates back to the 1930's.

The Blue Cross and Blue Shield Association and its member plans have been strong and continuous supporters of community-based health planning and the Federal role in planning provided for under the Federal Health Planning Act. When we first became involved in health planning, its role was very much one of controlling supply through capital reimbursement. And capital reimbursement is certainly the most significant piece of a total health planning program. However, it should not be viewed as independent of the other pieces of an effective program. Therefore, our comments today are directed to the future of the whole health planning system.

Since we last testified before you on the subject of health planning, the dynamics of the health care marketplace have changed dramatically.

Today there is a new need for planning to appropriately manage the closure of excess capacity caused not by regulation but by the marketplace. Competition has been increasingly successful in identifying excess beds but competition should be complemented by a deliberative planning process that provides an orderly method to guide community resource reductions in an efficient and equitable manner.

This is not to say that health planning does not have a role in initiating reduction in the supply of capacity. Many communities rely on planning as the stimulus for bed reduction. Most Blue Cross and Blue Shield plans actively participate in such efforts to identify or reduce unneeded capacity. Our activities range from monitoring existing and planned hospital capacity to adjusting reimbursement policies to meet unusual circumstances associated with capacity reductions.

We would also note that health planning still serves the purpose of determining the need for new capital expenditures. This is particularly important in view of the emergence of new and very expensive technologies and the need to regionalize them for cost effectiveness. But in no case should that be the only or even the primary function of planning in today's health care system.

There is clearly an evolution of marketplace forces in the provision of health care and we believe that health planning should recognize the need to evolve and mature as well. And, just as community-based health planning needs to evolve as one means of achieving efficiency and equity in health care delivery, we believe the role in planning must also adapt.

The Blue Cross and Blue Shield Association supports the reauthorization of Federal health planning through the Federal Health Planning Act. We believe, however, that the Federal program should be modified to better reflect the differences in local needs. In order for the Federal program to support these often unique local needs, we believe the law should reflect two principles:

First, that the Federal Government, through the Federal Health Planning Act should encourage but not dictate community planning. It should provide policy, technical and some financial assistance subject to very modest qualifying criteria.

State governments should be allowed the option of dealing with the problem of capital supply through mechanisms they deem appropriate to their environment. They should have the option to apply for Federal support by establishing a program which meets minimum Federal requirements.

We believe that excessive specifications for regulation of State and local programs, priorities and responsibilities should be eliminated. For example, the requirements for States seeking funding should be limited to the preparation of a State plan and the maintenance of a capacity control process related to this plan.

While under this optional system, some States might forego health planning, others will become more resourceful and effective in achieving an organized allocation of resources. As part of the support to States, we believe the current research, clearinghouse and technical role of the Federal Government should be maintained.

Second, that local communities should be encouraged to become involved in health planning. Their involvement should not be an artificial creation of the Federal Government but should represent a genuine commitment.

While we support continuation of a modest level of Federal financial support, the survival of community-based health planning should depend in part on local funding support. We recognize that such support will vary depending on local circumstances and priorities. However, the reality of community interest in health resources allocation should and will be tested by the commitment of local resources to the planning process.

States should continue to be able—and should be encouraged—to delegate plan development for an area to local planning bodies. Should an area elect not to participate or fail to meet State criteria, the State would assume planning responsibilities for that area.

As an additional incentive for local participation, the Federal Government could provide States additional funding expressly for the purpose of supplementing community support from local governments, businesses, and others interested in local health planning.

Mr. Chairman, we appreciate the opportunity to present these general comments. The short lead time for this hearing and the fact that no specific proposals are currently before the committee limits our ability to provide more specific suggestions on how to amend the FHPA.

Nonetheless, there is one specific provision we would immediately bring to your attention and urge its deletion; it is section 1531(3)(E) which includes health insurers in the definition of "provider of health care."

We are in the process of examining the effectiveness of the health planning programs participated in by Blue Cross and Blue Shield plans, determining whether there are particular technical issues that need to be dealt with, and looking at the long-term need for Federal health planning.

We will be pleased to follow up with committee staff with our more technical comments. However, we do urge you to reauthorize funding for health planning through the Federal Health Planning Act, recognizing that no single health planning model will suit all environments and that the act should provide for Federal incentives and support, State program management, and local choices.

Thank you.

[Ms. Lanam's prepared statement follows:]

PREPARED STATEMENT OF LINDA L. LANAM

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Since we last testified before you on the subject of health planning, the dynamics of the health care marketplace have changed dramatically. Today there is a new need for planning to appropriately manage the closure of excess capacity caused not by regulation but by the marketplace. Competition has been increasingly successful in identifying excess beds but competition should be complemented by a deliberative planning process that provides an orderly method to guide community resource reduction in an efficient and equitable manner.

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We would also note that health planning still serves the purpose of determining the need for new capital expenditures. This is particularly important in view of the

emergence of new and very expensive technologies and the need to regionalize them for cost effectiveness. But in no case should that be the only or even the primary function of planning in today's health care system.

There is clearly an evolution of marketplace forces in the provision of health care and we believe that health planning should recognize the need to evolve and mature as well. And, just as community-based health planning needs to evolve as one means of achieving efficiency and equity in health care delivery, we believe the federal role in planning must also adapt.

The Blue Cross and Blue Shield Association supports the reauthorization of Federal health planning through the Federal Health Planning Act. We believe, however, that the federal program should be modified to better reflect the differences in local needs. In order for the federal program to support these often unique local needs, we believe the law should reflect two principles:

First, that the federal government, through the Federal Health Planning Act should encourage but not dictate community planning. It should provide policy, technical and some financial assistance subject to very modest qualifying criteria. State governments should be allowed the option of dealing with the problem of capital supply through mechanisms they deem appropriate to their environment. They should have the option to apply for federal support by establishing a program which meets minimum federal requirements. We believe that excessive specifications for regulation of state and local programs, priorities and responsibilities should be eliminated. For example, the requirements for states seeking funding should be limited to the preparation of a state plan and the maintenance of a capacity control process related to this plan. While under this optional system, some states might forego health planning, others will become more resourceful and effective in achieving an organized allocation of resources. As part of the support to states, we believe the current research, clearinghouse and technical role of the federal government should be maintained.

Second, that local communities should be encouraged to become involved in health planning. Their involvement should not be an artificial creation of the federal government but should represent a genuine commitment. While we support continuation of a modest level of federal financial support, the survival of community-based health planning should depend in part on local funding support. We recognize that such support will vary depending on local circumstances and priorities. However, the reality of community interest in health resources allocation should and will be tested by the commitment of local resources to the planning process.

States should continue to be able—and should be encouraged—to delegate plan development for an area to local planning bodies. Should an area elect not to participate or fail to meet state criteria, the state would assume planning responsibilities for that area. As an additional incentive for local participation, the federal government could provide states additional funding expressly for the purpose of supplementing community support from local governments, businesses, and others interested in local health planning.

Mr. Chairman, we appreciate the opportunity to present these general comments. The short lead time for this hearing and the fact that no specific proposals are currently before the committee limits our ability to provide more specific suggestions on how to amend the Federal Health Planning Act. Nonetheless, there is one specific provision we would immediately bring to your attention and urge its deletion; it is Section 1531(3)(E) which includes health insurers in the definition of "provider of health care."

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TESTIMONY
OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman and members of the Subcommittee, I am Linda L. Lanam, Executive Washington Representative of the Blue Cross and Blue Shield Association, the national coordinating agency for the member Blue Cross and Blue Shield Plans.

We appreciate the opportunity to share with you our thoughts on the need for a federal role in health planning. Our views are based on the knowledge and experience gained by the Blue Cross and Blue Shield organization through a long-standing involvement in community health planning. This involvement dates back to the 1930s and extends throughout the years of the Hill-Burton program, the Community Health Planning Centers, the National Health Planning and Development Act, and, most recently, the emergence of voluntary community health care coalitions.

The Blue Cross and Blue Shield Association and its member Plans have been strong and continuous supporters of community-based health planning and the federal role in planning provided for under the Federal Health Planning Act. When we initially became involved in health planning, its role was very much one of controlling supply.

In the last few years, and indeed since we last testified before you in 1982, the dynamics of the health care marketplace have changed dramatically. Public and private third party payers have adopted payment mechanisms that put providers at financial risk and they are pursuing aggressive management of the use of health services. Importantly, major incentives and programs of management are now in place to move care, when appropriate, from inpatient settings to physicians' offices, hospital outpatient departments and ambulatory surgery centers. This approach to financing — really, managing — health care has led to a different need for health planing in many areas. That new need is

to manage the closure of excess capacity caused not by regulation but by the marketplace. The growing success of competition in reducing excess beds should be complemented by a deliberative planning process that maximizes the community's best interests. It is critical to provide an orderly community process to guide resource reductions in an efficient and equitable manner. Competition and regulation need not be mutually exclusive concepts. Used together, they can be valuable cost containment tools.

This is not to say that health planning no longer has a role in initiating reduction in the supply of capacity. Many communities continue to rely on planning as the stimulus for bed reduction. In fact most Blue Cross and Blue Shield Plans continue to participate in efforts to identify or reduce unneeded capacity. These activities range from monitoring existing and planned hospital capacity to adjusting reimbursement policies to meet unusual circumstances associated with capacity reductions.

Health planning still serves the purpose of determining the need for new capital expenditures. This is particularly important in view of the emergence of very expensive technologies and the need to regionalize them for cost effectiveness. But in no case should that be the only or even the primary function of planning in today's health care system.

There is, however, clearly an evolution of marketplace forces in the provision of health care and we believe that health planning should be recognized as a process that needs to evolve and mature as times change and as the strengths and weaknesses of various community approaches to controlling cost emerge. And, just as community-based health planning needs to evolve as one means of achieving efficiency and equity in health care delivery, we believe the federal role in planning must also continue to adapt.

The Blue Cross and Blue Shield Association supports the reauthorization of the Federal Health Planning Act. We believe, however, that the federal program should be modified to better reflect the differences in local needs. In order for the federal program to support unique local needs, we believe the law should be amended to reflect two principles:

First, that the federal government, through the Federal Health Planning Act should encourage but not dictate community planning. It should provide policy, technical and some financial assistance subject to very modest criteria. State governments should be allowed the option of dealing with the problem of capital supply through the mechanisms they deem appropriate to their environment. They should have the option of applying for federal support by establishing a program which meets minimum federal requirements. We believe that excessive specifications for regulation of state and local programs, priorities and responsibilities should be eliminated. For example, the requirements for states seeking funding should be limited to preparation of a state plan and maintenance of a capacity control related to this plan. While some states might forego health planning, others would become more resourceful and effective. As part of the support to states, we believe the current research, clearinghouse and technical role of the federal government should be maintained.

Second, that local communities should be encouraged to become involved in health planning. However, they should have a genuine commitment. Their involvement should not be an artificial creation of the federal government. While we support continuation of a modest level of federal support, the survival of community-based health planning should depend in part on local funding support. We expect that such support will vary

depending on local circumstances and priorities. The reality of community interest in health resources allocation will be tested by the commitment of local resources to the planning process.

States should continue to be able — and should be encouraged — to delegate plan development for an area to local planning bodies. Should an area elect not to participate or fail to meet state criteria, the state would assure planning responsibilities for that area. As an additional incentive for local participation, the federal government could provide states additional funding expressly for the purpose of supplementing community support from local governments, businesses, and others interested in local health planning.

Mr. Chairman, we appreciate the opportunity to present these general comments. The short lead time for this hearing and the fact that no specific proposals are currently before the committee limited our ability to provide more specifics on how to amend the FHPA. However, we are in the process of evaluating the effectiveness of health planning generally, determining whether there are particular technical issues that need to be dealt with, and examining the long-term need for federal health planning. We will follow up with committee staff with our more technical comments, however, we do urge you to reauthorize the Federal Health Planning Act to recognize that no single health planning model will suit all environments and to provide for federal incentives and support, state program management, and local choices.

Mr. WAXMAN. Thank you very much.

Ms. Lanam, you made a persuasive case for the necessity of health planning, but then indicated that we should leave it optional with the States rather than mandating it. Should we be concerned that some States may choose not to have a planning program, even though it is readily apparent, for the reasons you have noted, that they should have one?

Ms. LANAM. I think there is reason for concern that some States will forgo the option. My belief is that an effective health planning system with the appropriate amount of flexibility that would be designed in a good program would encourage them to participate, because they would not feel that they couldn't design a program that met their needs. Therefore, I think the concern could be alleviated by the way in which the programs were designed, and States would feel that with the appropriate amount of flexibility, and the needs of the changing marketplace that have to be met, there would be encouragement for them to participate.

Mr. WAXMAN. Mr. Owen, could you respond to Ms. Lanam's points that we need a planning process to make sure that the reduction in excess capacity is done in an equitable and efficient way?

Mr. OWEN. I would be happy to, Mr. Chairman. I am not so interested in reducing the excess capacity in the fashion of just closing those beds down. I think this country will be faced in the future with an aging population and a need for some long-term beds other than acute care, and to close those beds down and get rid of them, so to speak, may be the most costly venture we could undertake, and probably one of the reasons why we need planning more than any other reason, to see that those facilities which are already available are used in a way which makes sense other than an acute care facility.

So I am not prepared to say that there ought to be planning to close them down. I am prepared to say that we ought to have planning to see how they can be utilized to better provide health care for the citizens of this country.

Mr. WAXMAN. I suppose the only way to reduce excess capacity is not just to close down facilities, but to talk about expansion of facilities. The question is what would be the equitable and an efficient way. Do you think that excess capacity is not a problem?

Mr. OWEN. Well, it depends. It is not a problem when you look at the way that prospective pricing is being utilized, because no one is paying for those beds, where under the old cost reimbursement system the cost there was. An empty bed was a costly bed. As we move more into a prospective pricing system by industry and Government, we find that that cost is not as great as it was. Although the beds are there, they are empty, nobody is paying for them, so that I am not sure that we are in the same kind of a situation.

In other words, what has happened is we have got those excess beds because we have a new system which has reduced the length of stay, has reduced the number of admissions, and the costs to the trust fund which everybody will agree has gone down considerably, the length of the trust fund before bankruptcy is now up to the year 2000, when it was supposed to be bankrupt in 1987, so that something is happening.

Now the question is, we have those beds, how can we best use them for the good of the country and the citizens in the future, rather than just eliminating them and saying, well, the best way to get rid of them is to close this hospital down or close this wing down or get rid of the service in this community. I think the issue is how do we provide access in the community, and what is the best kind of access we should have, and what is the best kind of service we should provide. It is not acute care, we recognize that.

Mr. WAXMAN. If there is an empty bed, won't a hospital try to fill it?

Mr. OWEN. That is an old myth that under the old system of cost reimbursement was very true, but it is not true now. Our severest critics in the hospital field said what would happen in the prospective pricing system was when we shorten the length of stay, hospitals would just go out and increase the number of admissions. Yet we had a 2.9 percent dropoff in over 65 admissions last year and overall a drop of others, so hospitals are not filling them.

Mr. WAXMAN. How do you explain that dropoff in admissions?

Mr. OWEN. There are probably a lot of reasons but the dropoff in admissions primarily stems from the fact that physicians and hospitals are now looking at this whole system in a different fashion. More physicians are taking care of patients in their offices and in clinics and outside facilities where they used to admit the patient, because that was part of the system, so that that is occurring.

People are more conscious, outside of the Medicare patient, where people are participating in their health benefits, that they were paying a bigger and bigger share. Where it used to be comprehensive health coverage, now they pay a deductible, and if I am working for a company that says the first thousand dollars is yours, you are more reluctant to go to an expensive hospital if you can have whatever is needed to be done in a doctor's office or in an outpatient clinic.

So we are seeing a whole change in the attitude of people, of hospitals, of physicians, and it is a combination of competition, of surplus of physicians, of a change in the way the payment system works all coming together. And the effect is fewer admissions, shorter length of stay and using different facilities to care for people than hospitals.

Mr. WAXMAN. It is just hard to see where that is going. We are pleased to see a drop in admissions if people are being taken care of adequately elsewhere, but you would think under the DRG system the hospitals would want to have more admissions, since there is a payment per diagnostic group, and would therefore be pushing the doctors to admit more patients.

On the other hand, you can say to me hospitals don't have an influence over doctors. Yet there are some reports that hospitals seem to be influencing doctors to terminate the stay at the hospital sometimes earlier than would otherwise be the case. That may or may not be good medically. How do you deal with that apparent contradiction?

Mr. OWEN. It is, I guess, a contradiction, as you have put it, but physicians admit patients and they still discharge patients. Hospitals don't. But granted that hospitals do provide pressures and their peers provide pressures and the board of trustees is ultimate-

ly responsible to provide some pressures on the economics of the institution. I don't think you are seeing, first of all, that hospital administrators are saying to doctors, "You have got to get a patient out before they are ready." I think there is a perception problem in this country.

We have done a good job of telling the elderly that they are not going to have to pay any more under the prospective pricing system than they used to pay under the old cost reimbursement system. We haven't done a very good job to tell them: You are not going to stay in there as long as you used to. You are going to have to get out much faster. They go in for a gall bladder and they are out in 4 days and their neighbor was in for 11 days, so the perception is I was let go too fast.

The other is a real one, perhaps, that sometimes they go back and they are not quite as mobile as they would have been if they stayed 2 more days. They can't go to the bathroom or cook as well as they could and there is a transition period that we have got a problem with. We are going to have to correct that somewhere along the line. That is beside the point, but as far as the admissions are concerned, the physicians are not admitting more patients into the hospital.

The facts are there. I mean, they have dropped dramatically both over 65 and under 65, so that it is an attitude and a way of practice that is determined on the basis of, or was determined in the way of economics. It was a cost reimbursement system that got put in. Everybody paid for it. Nobody cared. Now we do, and I think it is for the good, and I see no indication statistically in any region, any part of the country, where we are seeing an increase in admissions because there is pressure on physicians to admit those patients. It is not happening.

Mr. WAXMAN. Do you think the reports about early releases of patients from hospitals is solely one of perception by the patients themselves who have different expectations, or are we seeing some statistics that indicate that patients are being released earlier from hospitals?

Mr. OWEN. We know they are being released earlier. That is a fact. We are not seeing any statistics that show that there are readmissions that are over and above what they ever were. We are not seeing any statistics that show that people are dying because of it. We are not seeing any statistics that indicate that the quality of medical care has necessarily gone down. We are seeing two things. One is a perception by the patient of how long they think they should be in the hospital. The other is a real situation, in which the patient is told he must leave, and he is not quite as capable—I don't want to use the word sicker because I don't think they are sicker, but they are not as mobile and they are not as ambulatory and they can't do the things that a couple more days of being in a hospital would allow them to do.

The problem is you can't put those patients necessarily in a nursing home, because they need a little more sophisticated care than a nursing home now provides, and they don't want to take them. You can't really send them home because the problem is at home there may be no one who can provide that supervision or take care of them quite as much, unless there is an awfully good home health

care program. So we have a transition of a few patients that we have really got to worry about, because it is more than perception.

It is not an acute care problem, but it is a social health problem as far as that individual is concerned, and there needs to be some kind of transition period. Maybe some of those empty beds, for instance, that we are talking about, should be used in a transition, in which there are marginal costs and a price paid for that 2 or 3 days that people need where they used to stay and nobody cared.

Mr. WAXMAN. With this remarkable turnaround of fewer admissions and shorter stays, we are achieving success, if you measure the question of success on the basis of holding down hospital costs. There are some people who have argued that therefore we could freeze the DRG payments to hospitals next year at the same level. I know this hearing wasn't on that subject, but I would be curious, since it is on our minds here in Congress as we examine the budget. What would be your evaluation of that proposal?

Mr. OWEN. Mr. Chairman, I am happy to comment on that. I think it is terrible to freeze the rates. The hospitals went into this system on the basis that they would try to live up to what the Government wanted them to do, hold down admissions, hold down length of stay, and the Government side of it said when you do that we will set a price and then we will put a market basket increase to keep up with inflation so that you can continue to provide the same quality and access that you provided.

And what has happened is in the meantime everybody said the hospitals are going to game the system. What happened is the Government is gaming the system. They have in effect in this year, in 1985, we were supposed to get market basket plus 1 percent, and we are ending up with a 5-percent increase, because they lowered the weights in the prices, and that means in fiscal year 1985 hospitals will get a 4-percent increase with a possible freeze coming up in 1986.

It means hospitals will go 2 years with only that one 4-percent increase, with the cost of living going up 4 or 5 percent this year and possibly 5 percent next year. That means we will drop behind the cost of living about 6 percent by the time we finish the second year. That has got to have an effect on access somewhere along the line, but quality of care is hard to pinpoint.

We know it is going to occur and it will be insidious, but on the access issue, which is more important, hospitals will start to stop a service. They won't close down, but they may go out of the business of doing hip replacements. They may go out because the fixed cost is going to be more than the price that the Government has frozen, and you can't continue to operate when your price is less than your fixed costs.

Mr. WAXMAN. Some of my colleagues on the Ways and Means Committee who deal with part A of Medicare tell me that, aside from the official positions of the hospital industry, they are hearing from people that there is enough fat in the system that hospitals can absorb a freeze. I keep on repeating the statements I hear at my hearings about what the impact would be, and they keep on saying to me, don't worry. What is going on? Do you think there are other groups in the hospital industry that are privately telling people don't worry about it?

Mr. OWEN. No. I think what has happened is that the hospital industry, like the rest of this country, feels that the overall budget deficit of \$230 billion is affecting this whole country, and that we have a role to play in that like everybody else, and if we get a freeze we will have to live with that freeze, and we will do the best we can.

We don't feel that the hospitals should be singled out to be cut while other programs are increased or not touched. That we will fight completely, but if it is across the board, we have to live with it, to get that deficit down, because the \$130 billion you are paying in interest payments every year would take care of most of our health care needs in the whole country.

We need to get it down, we will live with it, but I think my hospitals are not really realizing that although they may have done fairly well last year, that with the small increase this year, and none next year, by the time they get to the end of that second year, we are going to have some problems.

I think the hospitals that have looked at that closely realize that they are going to be struggling.

Mr. WAXMAN. You said in your testimony we should not turn back the clock to a time when hospitals were considered a poor financial risk. What is the situation today? I am under the impression that many people in the capital business view many, if not most, hospitals to be a poor risk.

Mr. OWEN. We are not finding that too much across the country on hospitals that are going out for tax-exempt bonds and other financial things, but there hasn't been any real growth because of the occupancy problem. There hasn't been a big movement to build more hospitals. The economics—you don't need planning to tell you you can't afford it.

But, to my knowledge, in the surveys that we have done, we have not found that it is a financial problem for hospitals at this point in time. Now, if we go through a freeze, that may change things, but at this point in time, most capital organizations want to know what the bottom line is, and if the bottom line looks pretty good, then the hospital has a chance to borrow. If it doesn't, they don't.

Mr. WAXMAN. Doesn't that mean that hospitals that have a disproportionate share of poor people are in trouble?

Mr. OWEN. As far as gaining capital, you are absolutely correct. Those with a disproportionate share have a much more difficult time obtaining capital than those who don't have that disproportionate share. That is why we feel very strongly that something should be done to help those hospitals who have a disproportionate share.

One of the things you could do, Mr. Chairman, is, instead of giving the \$64 million to planning, give it to the hospitals who have a disproportionate share, and that would solve some problems right away.

Mr. WAXMAN. I will think about that advice. Thank you very much, both of you, for your testimony. I think it has been very helpful and we look forward to working with you.

Mr. OWEN. Thank you.

Mr. WAXMAN. Our next panel, I would like to call forward Dr. Donald Schneider of Health Systems Management, Rensselaer

Polytechnic Institute, Troy, NY, and Charles F. Pierce, Jr., Deputy State Commissioner of Health, New Jersey Department of Health. We are pleased to welcome both of you to our hearing today. As you know, your statements are part of the record and we would like to have you summarize those statements. Mr. Schneider, why don't we start with you.

STATEMENTS OF DONALD SCHNEIDER, DIRECTOR, HEALTH SYSTEMS MANAGEMENT, RENSSELAER POLYTECHNIC INSTITUTE; AND CHARLES F. PIERCE, JR., DEPUTY STATE COMMISSIONER OF HEALTH, NEW JERSEY DEPARTMENT OF HEALTH

Mr. SCHNEIDER. My name is Don Schneider, director of the Health Systems Management Program at RPI. I am very pleased and honored to have the opportunity to make this presentation on the relationship between health planning and capital markets. I will concentrate on, first, where do hospitals obtain their capital; second, how do the capital markets view hospitals, in light of the Medicare prospective payment system, prospective capital reimbursement and health planning; and third, what are the implications for health planning.

Under the sources of capital, where hospitals obtain their capital has undergone a complete shift in the last 15 years. In the period from 1968 to 1983, direct Government funding and philanthropy, for voluntary nonprofit hospitals, dropped from 41 percent of the total capital raised, to only 5 percent of the total. Currently the sources of capital are as shown below.

This demonstrates that capital now comes primarily from debt with hospital reserves a very distant second. The table also demonstrates that the sources of capital vary significantly between voluntary hospitals, investor-owned and State and local hospitals.

How do the capital markets view the changes in the health care system?

The main response is one of confusion and general uncertainty. There is a general belief that while there is a risk posed by the DRG's and by competition, that most hospitals will come out very well. If we look at the bond market carefully, some very interesting paradoxes can be observed.

In the last year, bond ratings are going down. It isn't due to PPS—at least directly—competition or prospective capital reimbursement. It is because patient volume has dropped due to lower lengths of stay and the shifting of many services to M.D. offices.

The second point in spite of the bond ratings going down tax-exempt borrowing is going up—1984 was a record-breaking bond year. Hospitals financed \$10.5 billion through tax-exempt bonds in 1984 as compared to the previous record of \$9 billion. By way of further comparison, the figures for 1980 and 1981 are \$3.6 billion and \$5.0 billion respectively. In spite of this recordbreaking financing in 1984, it is interesting to note that only 25 percent of the hospitals in the United States have ever received a bond rating to receive tax-exempt bonds.

In fact, a very biased sample of top echelon hospitals are going to the market. It is not the very old hospitals with a deteriorating plant that comprise the bulk of the financing. The median account-

ing age of hospitals which receive bond ratings last year was only 6 years. We found that once a hospital passes an accounting age of 16 years they were very unlikely to access the capital markets. Accounting age is computed based on depreciation concepts and is generally much less than building age.

In rating hospitals it is perceived that two external factors—relating to this discussion—are important: reimbursement and competition. For many of the hospitals coming into the debt market, the Medicare PPS has positively impacted their financial performance. Prospective capital reimbursement may be a different matter. However, hospitals routinely now are asked to show they can meet their debt service obligations even if Medicare adopts a prospective capital system—many apparently have shown they can do it.

Health planning, per se, has only an indirect impact. It is seen as a component of competition, which is a central issue. Lack of a certificate of need process to protect the hospital from its competitors is perceived to be a serious impediment if the hospital is in a precarious competitive position.

FHA 242 programs for insuring the loans for hospitals that are otherwise unable to secure access to capital, insured loans for \$516 million in fiscal year 1984. This fiscal year it is on a record-setting pace with \$872 million currently pending. New regulations that allow public hospitals to use the program will further expand the program. The growth in the applications is apparently related to the growth of an underclass of hospitals who cannot otherwise obtain capital.

Hospital facilities go through a life cycle. Due to their age, many are at a critical point and are due for major renovation or rebuilding. Now is the time that the 75 percent of hospitals that have never been in the bond market need to be entering it. However, most of the hospitals that haven't yet accessed the capital markets will never access it on their own. Almost one half are under 150 beds. If the market continues to be the predominant decisionmaker in allocating capital, serious inequities in service provision may develop, forcing a future administration to establish a new Hill-Burton Program to revitalize segments of an aging hospital population.

As has been noted by many, we are seeing a consolidation in the industry. Mega-corporations are being created. If Congress supports this new form of organization, a transition strategy is needed. If not, then a different strategy is needed. As a start toward developing the easier parts of that strategy I would like to offer the following two principles:

There is a necessary role for health planning. That role should be to control and assure the supply of health care services—beds, nursing homes, clinics, other health-related programs.

Control of capital expenditures should be exercised through a prospective capital payment system which promotes efficiency and cost effectiveness. Health planning is the wrong mechanism to control capital expenditures.

These two principles, if adopted, could rationalize many Federal health policies. However, they are the easy part. A potentially key role for health planning relates to the treatment of the underclass of hospitals. They are growing in number, are not for profit, are

often small, and often cannot obtain capital on their own. In the long run, health planning may help to ensure competition, by ensuring these underclass of hospitals survive the short-run competition.

Hospitals currently finance 60 percent to 75 percent of their capital needs through debt. The capital markets have responded to the uncertainties in the health care system with generally lower bond ratings but at the same time have invested, with confidence, a record \$10.5 billion in tax-exempt bonds in 1984. The problems lie not with the investor-owned facilities or the 25 percent of the non-profits that have received funding from the bond markets—it is with the remaining 75 percent of the hospitals that have not, and probably will not, be able to access capital on their own.

Cost containment, for both operating and capital expenditures, should be pursued through prospective payment systems. The role of planning should be to control the supply of health care services and to assure the supply of health services through their treatment of the underclass of hospitals.

[Mr. Schneider's prepared statement follows:]

Testimony prepared by .

Don Schneider, Ph.D.
 Director, Health Systems Management
 School of Management
 Rensselaer Polytechnic Institute

INTRODUCTION

I am very pleased and honored to have this opportunity to make this presentation on the relationships between health planning and the capital markets. In my presentation I will concentrate on the following four points:

- o Where do hospitals obtain capital and what do they spend it on.
- o How do the capital markets view hospitals in light of Medicare PPS, prospective capital reimbursement, and health planning.
- o How are these issues affecting hospitals.
- o The implications for health planning.

SOURCES OF CAPITAL AND USES FOR CAPITAL

Where hospitals obtain their capital has undergone a complete shift in the last 15 years. In the period from 1968 to 1983, direct government funding and philanthropy, for voluntary non-profit hospitals, dropped from 41% of the total capital raised, to only 5% of the total. They have ceased to be a significant source of capital. Currently the sources of capital are as shown below:

SOURCES OF HOSPITAL CAPITAL			
	Voluntary	Investor Owned	State & Local
Reserves	16%	40%	15%
Philanthropy	5	0	2
Government	0	0	26
Tax exempt bonds	65	4	40
Loans & other	14	56	17

In other words, capital now comes primarily from debt with hospital reserves a distant second. Hospital reserves are built over the years through a combination of making profits, investing philanthropy, and saving the depreciation revenues received on current buildings and equipment (which Medicare and most third party payors pay). It is also clear from the table that the sources of capital significantly

differ for Investor-owned hospitals and not-for-profit hospitals. Investor-owned hospitals have a far greater variety of options for obtaining capital and more readily obtain needed capital.

Since hospitals have significant debt, they have large interest payments. Of the total dollars spent in hospitals, approximately 7% is for capital. Of that 7%, approximately 40% is for the building, 25% for equipment, and 35% is for interest.

Recent studies have estimated the capital "needs" of hospitals at \$100B to \$200B for the 1980s. There are many misconceptions about why hospitals are using all that capital. It is being used to renovate, rebuild and modernize the existing facilities rather than expand the number of beds. Currently only 10-15% is being used for expansion.

HOW DO THE CAPITAL MARKETS VIEW THE CHANGES IN THE HEALTH CARE SYSTEM?

The main response is one of confusion and general uncertainty. However, that is tempered with a general belief that things will work out all right. That while there is a risk posed by the DRGs and by competition, that most hospitals will come out very well. However, in uncertainty, the market tends to assume the worst and thus generally lower bond ratings are the result. If we look at the bond market carefully, some very interesting paradoxes can be observed.

Bond Ratings Are Going Down. More bond ratings are going down than up. However, it isn't due to PPS (at least directly), competition, or prospective capital reimbursement. It is because many hospital financial projections aren't being met. Patient volume has dropped due to lower lengths of stay and the shifting of many services to MD offices. Thus hospitals simply aren't meeting their revenue projections. However, there has never been a single hospital default on a tax exempt bond.

Tax Exempt Borrowing Is Going Up. 1984 was a record breaking bond year. Hospitals financed \$10.5B through tax exempt bonds in 1984 as compared to the previous record of \$9B. By way of further comparison, the figures for 1980 and 1981 are \$3.6B and \$5.0B respectively. More hospitals are getting more debt capital than ever before.

Very Few Hospitals Have Obtained Tax Exempt Bonds. In spite of the record financing in 1984, only 25% of the hospitals in the U.S. have ever received a bond rating to receive tax exempt bonds. A very biased sample of top echelon hospitals are going to the market. It is not the very old hospitals with a deteriorating plant that comprise the bulk of the financing. The median "accounting age" of hospitals which receive bond ratings is 6 years. We found that once a hospital passes an "accounting age" of 16 years they were very unlikely to access the capital markets. (Accounting age is computed based on depreciation concepts and is generally much less than building age.) There is definitely an evolution toward a growing underclass of hospitals - hospitals that can't or don't access the capital markets and can't compete.

Impact of Regulatory Programs. In rating hospitals it is perceived that two external factors (relating to this discussion) are important: reimbursement and competition. For many of the hospitals coming into the debt market, the Medicare PPS has positively impacted their financial performance. Prospective capital reimbursement may be a different matter. However, the capital markets have watched the capital reimbursement debate so long their eyes are getting tired. Thus it has faded in impact in their assessment of hospitals. Even if there were prospective capital reimbursement, many who come to the tax exempt market have only 35% Medicare, and show they can meet their debt service obligations even if Medicare adopts a prospective capital system.

Health planning, per se, has only an indirect impact. It is seen as a component of competition, which is a central issue. During the bond rating process, a careful examination of the competitors of the

hospital is performed. Thus, lack of a CON process to protect the hospital from its competitors is perceived to be a serious impediment for a hospital that is in a precarious competitive position.

FHA 242 Program. The FHA 242 program insured loans for \$516M in FY1984. In FY1985 it is on a record setting pace with \$872M currently pending. New regulations that allow public hospitals to use the program will further expand the program. The growth in the applications is apparently related to the growth of an underclass of hospitals. There are also increased applications for smaller loans (under \$20M) - loans that used to be financed out of reserves and fund drives.

New Wrinkles. For hospitals that meet the basic standards for tax exempt bonds, the market has invented credit enhancements to get better access and lower interest. (1) The most common is variable rate bonds with "put" features that are backed up by local banks who agree to buy back the tendered bonds. (2) Many are also buying loan insurance. In this case it is really the insurers credit rating which sets the bond rating with the result of lower interest and better credit. Naturally, the insurers pick and choose carefully using their own criteria for evaluating the hospital risk. (3) Many hospitals, particularly those sponsored by religious organizations, are forming bond pools to increase access. (4) Finally, in at least one case, a local industry guaranteed the bonds of a financially weak, but inexpensive hospital. They did so to ensure access by their employees to the inexpensive, small community hospital and thereby avoided everyone going to the financially strong, but expensive, medical center.

Summary. Hospitals currently finance 60-75% of their capital needs through debt. The capital markets have responded to the uncertainties in the health care system with generally lower bond ratings but at the same time have invested, with confidence, a record \$10.5B in tax exempt bonds in 1984. The problems lie not with the Investor-owned

facilities or the 25% of the non-profits that have received funding from the bond markets - it is with the remaining 75%.

HOW ARE THESE ISSUES AFFECTING THE HEALTH CARE SYSTEM?

As is true in any industry, competition in hospitals leads to winners and losers. Without government intervention, market forces will take over and drive many hospitals into bankruptcy. However, many hospitals that exit from the market may be forced out because of their location or payor mix, rather than forces under their control. We need to understand the impact these forces will have and thus determine what, if any, interventions are in the public interest.

Hospital facilities go through a life cycle. Many hospitals are currently at a critical point in their life cycle, because of the period of time which has elapsed since the major expansions which occurred during the Hill-Burton program and the passage of Titles XVIII and XIX. It is now the time that the 75% of hospitals that have never been in the bond market need to be entering it. However, as I noted before, the average hospital that enters the market is 6 years old (accounting age) while those over 16 rarely access the market. In other words, the hospitals which obtained capital in the recent past are most likely to be the ones to access the capital markets again.

Most of the hospitals that haven't yet accessed the capital markets will never access it on their own. Almost 1/2 are under 150 beds. Many will likely choose to sell out to a for-profit or not-for-profit chain when faced with lack of access to capital. Others will be converted to other uses (e.g., nursing homes), and others will go out of business. If the market continues to be the predominant decision-maker in allocating capital, serious inequities in service provision may develop, forcing a future administration to establish a new Hill-Burton program to revitalize segments of an aging hospital population.

THE IMPLICATIONS FOR HEALTH PLANNING

As has been noted by many, we are seeing a consolidation in the industry. Mega-corporations are being created. If Congress supports this new form of organization, a transition strategy is needed. If not, then a different strategy is needed. As a start toward developing the easier parts of that strategy I would like to offer the following two principles:

- o There is a necessary role for health planning. That role should be to control and assure the supply of health care services (beds, nursing homes, clinics, other health related programs). It is not unnecessary duplication of services that concerns me most, it is the provision of unnecessary services OR the converse, lack of necessary services, that is of greatest concern. The many fine studies on small area analysis have shown that the number and type of services provided are most highly correlated with what is available.
- o Control of capital expenditures should be exercised through a prospective capital payment system which promotes efficiency and cost effectiveness. The current capital pass through is inherently inflationary and has incentives for inefficient investment behavior. Health planning is the wrong mechanism to control capital expenditures.

These two principles, if adopted, could rationalize many federal health policies. However, they are the easy part. The harder part is in deciding whether a consolidated, competitive, mega-corporation health care system will fit our needs. And if not, what to do about it. Would there be any role for health planning besides control of services. Reimbursement has been shown to be an effective way to control operating costs. Prospective capital reimbursement has the right incentives to encourage efficient and effective use of capital. Competition has led to innovation in programs and cost containment. The pieces that are missing are as follows:

- o Competition encourages the growth of services and seeks, by the very nature of competition, to build or expand the market as well as the market share.
- o Reimbursement controls the cost per unit of service, but cannot address whether the service is needed.
- o A potentially key role for health planning relates to the treatment of the underclass of hospitals. They are growing in number, are not-for-profit, are often small, and often cannot obtain capital on their own. In the long run, health planning may help to ensure competition, by ensuring these underclass of hospitals survive the short run competition.

Summary. In spite of the record breaking access to the health care capital markets, many hospitals have not, and probably will not, be able to access capital on their own. Current forces are shaping a health care system dominated by mega-corporations coupled with an aging underclass of hospitals. Cost containment, for both operating and capital expenditures, should be pursued through prospective payment systems. The role of planning should be to control and assure the supply of health care services.

Mr. WAXMAN. Thank you, Mr. Schneider.
Mr. Pierce.

STATEMENT OF CHARLES F. PIERCE, JR.

Mr. PIERCE. Thank you, Congressman Waxman. It is a pleasure to be here and speak before the hearing. I am Charles Pierce, deputy commissioner of health for the State of New Jersey. Under my responsibility is the rate-setting program for the DRG pacesetter, planning, certificate of need and the licensure and inspection of health care facilities.

I was asked to speak to the fairly narrow issue of what does a State do with certificate of need that also has a well-entrenched and established rate-setting program. The much maligned certificate of need program, which has had many errors and many failings, including in our State, has proven to be a limited but extraordinarily valuable instrument of public policy, and one that we want to see extended into the future.

What I would like to tell you about is the way that certificate of need has evolved in New Jersey, and how we believe we are able to use it as an instrument of public policy.

One, we believe that it's major focus is for the control of new technology, such as MRI's lithotripters. New Jersey, by the way, just issued certificates of need for eight MRI's.

We believe that it is very important that when new technology comes on line that the certificate of need be used for both geographical and economic distribution throughout the State and make sure that there is access both on a geographic and on an economic basis.

The second place where it is of major significance in our view is where the health care system is going through very dramatic change in delivery style, such as free-standing ambulatory surgical programs. As various providers try to establish their place in the market, we feel it is very important at this point in time, because we don't know the fallout or how it is going to work, that it be controlled to protect the resources already in place as well as to assure access.

Obviously, very large ticket items are equally important and have been a traditional role for certificate of need, and we continue to use it in that way.

I think what I would like to do is share with you how we have gone about approving certificates of need, and the conditions that we have attached to them, to show you how it has been evolving. One is that we have required all recipients of the certificate of need that they provide uncompensated care, bad debts and charity care, in an amount similar to what the hospitals in the area are already providing.

In other words, if a hospital is looking at diversification and wants to spin out a radiology service, or go into an ambulatory surgical program, and we say that there is need for that, we make sure that they get that certificate of need along with a commitment to care for the medically indigent in the same amount that the hospital already provides.

A second requirement on certificate of needs, at least for high technology, is that they provide the ability for graduate medical education to occur in that particular program.

Third, we too are very conscious about the need to make hospitals and providers sensitive to the marketplace. In years past many major projects were done with total deficit financing. We now have an equity contribution of 15 percent. We do allow a discount for large hospitals with uncompensated care. For every percent that they provide, they can discount half a percent of their equity requirement. We believe that this has added a tone of discipline to the marketplace that is very important.

There have also been places with high-technology services, we have added a requirement to the price, and said "if you are going to give this service, such as cardiac surgery, you have to do it within 2 years at the average price for cardiac surgery throughout the State."

I will just close by giving you a few examples of where I believe in the recent year certificate of need has been a valuable tool for us. One is I have been having a dialog with a hospital president who wants to merge his institution with a weaker one, and he called and said: "This is a great thing for the State and the health care system. We are going to reduce beds, consolidate services, close an E.R. room. What a fabulous saving. The only price is we want a linear accelerator."

We looked at that and said: "But there is one 3 miles away, and that is the place where the State is supporting the growth of that program."

Much dialog later, and we repeating the "No" we said: "You can go into the public process and try for a C.N. if you want, but the State will not support it."

I hadn't heard from the gentleman until last week, when he told me that the merger would be coming forth in 2 months, and there is no linear accelerator.

The other place where I think it has been useful is looking at the MRI question. New Jersey put together an advisory committee, established a set of criteria for what should be the appropriate dispersion and what kind of institution should receive it. Then we put out those same criteria, and we had 13 applicants.

We asked the same group of experts—it had finance people, it had consumers and it had radiologists involved—and they came back with the recommendation of what they thought were the eight best applicants.

For each of them we have accepted the recommendation of this advisory committee. They are now going to be geographically distributed throughout the State. They all have a minimum requirement of 15 percent equity. They must all give medical students the ability to use to use the machine. For all of them they must also include a research protocol both in terms of the future of MRIs as well as the financing of MRI's. They have included hospitals and combinations—these are consortiums largely, of community hospitals and teaching hospitals, and in several situations included private doctors.

We believe that the C.N. instrument is a valuable tool. We would support it, and if in the future you are examining health planning

legislation more closely, we would be delighted to give you the rest of our ideas on the subject. Thank you.

Mr. WAXMAN. Thank you very much, Mr. Pierce.

Will we be able to control or limit total hospital expenditures under Medicare in an effective manner, if we do not control or limit capital expenditures in some fashion?

Mr. PIERCE. No. Yours is a complex question with many brilliant minds looking at it. We are very concerned about the control of capital. New Jersey has an excellent financing authority. We have about 50 to 60 bonds, about a \$2 billion debt. How, and what kind of policy Congress makes in terms of capital reimbursements is going to have an enormous impact on the future.

I think at this point in time, one thing we would like to put out on the table is that the answers may well be very different State to State, and we would like to see the answer include the ability for States to make their own particular response to the problem.

Mr. WAXMAN. Mr. Schneider, I would like you to respond to that question.

Mr. SCHNEIDER. I also agree that without control of capital, that cost containment would be difficult. I think that competition as a strategy, like in all industries, tends to encourage growth in the market, and will encourage growth and share. Reimbursement can adequately control the cost of service but can't really control how many services are provided and demanded.

We have got many small examples of small area analysis which show that what services are provided are basically related to what services are available, and so without capital controls, without control of services, I think we will see excess use of services, and therefore higher costs.

Mr. WAXMAN. Mr. Schneider, I was interested in your statements about the private capital market borrowing and investment and proprietary institutions as the predominant source of capital for hospitals. I am interested in the effect which this has on distribution of capital and in turn access to hospital care for Medicare and Medicare beneficiaries and the poor.

If we were to pay for capital under Medicare on the basis of some kind of formula and relied on market forces to govern the distribution of capital among hospitals, which hospitals would find it easier to obtain the capital? I guess the answer is obvious since—what is it?—\$10 billion has been raised to go to one-quarter of hospitals.

Mr. SCHNEIDER. Yes.

Mr. WAXMAN. What happens to the other three-quarters?

Mr. SCHNEIDER. Generally those hospitals with the higher proportion of Medicare and Medicaid patients are the ones that have greater troubles now of accessing capital, and under a prospective capital payments system, that would be exacerbated. I think there are options around that.

If a prospective capital payments system were implemented, it may be necessary or possible in essence allow some hospitals not to operate under such a program, because under such a program, they may find capital virtually impossible to obtain. That could be a role of health planning, to determine which hospitals, because of their role in the community and their general weaknesses, could need that type of protection.

Mr. WAXMAN. So health planning offers some limited way to equalize the distribution of capital; to avoid the flow of money to only those hospitals that will serve those that are fully insured; to assure that some capital goes to those that serve the disproportionate share of Medicare, Medicaid, and the poor?

Mr. SCHNEIDER. I would agree with that.

Mr. WAXMAN. Is that going to be the total answer for those hospitals? Are they still going to be able to get capital?

Mr. SCHNEIDER. I think that there are other possibilities as well for those hospitals, and one of them is that they may need additional Government subsidies through additional loan insurance. Again, that could be a role of health planning to deal with who would get access to those types of Government subsidies. Some States such as New York have indigent care pools, and allocation of those pools is an important issue for hospitals that are serving large numbers of the indigent.

Mr. WAXMAN. You talked about the prospect of a Hill-Burton type program for what would be I guess the inner-city hospitals, or the hospitals taking a disproportionate share of patients. Do you see that as a realistic demand upon the Government?

Mr. SCHNEIDER. I don't think we are anywhere close to that point yet, but, as I noted before, because of the age of hospitals that were built during the Hill-Burton era, and with the expansion of the Medicare and Medicaid Program in the mid-sixties, we are moving to the point where there are large numbers of hospitals getting to the point where they need to rebuild and renovate. Someone will have to step in with some solutions.

Mr. WAXMAN. So this problem is coming at us a couple of years down the road. The decisions we make today will affect very much what will happen when we get to that point?

Mr. SCHNEIDER. That is correct.

Mr. WAXMAN. Mr. Pierce, what are the older hospitals in New Jersey doing for capital?

Mr. PIERCE. Some of them have been fortunate, and have been able to get access to the market. It has only been, though, with the help of FHA insurance. Without FHA insurance, their deals never would have been sold. There are other hospitals that did not need FHA. New Jersey with its DRG waiver, at least as it has stood, was able to create a payment system that reimbursed hospitals for the medically indigent. I think almost every speaker has been alluding to the fact that the medically indigent is that weak thread which we are all concerned about, and again everyone is going to have to try to respond to that in a responsible way.

We do have some inner-city hospitals that are of marginal use. Their admissions are dropping off, and I suspect in time you will see some closures. But New Jersey is in kind of a transition period, that as long as our waiver holds, or we are able to find resources to pay for medically indigent, a well-run inner-city hospital, with the help of the FHA, does have access to the market.

Mr. WAXMAN. Let me thank both of you for your testimony today, your participation in this hearing, and as we work on legislation we would like to have further inputs from you.

Mr. PIERCE. Thank you.

Mr. WAXMAN. We have as our next witness a representative of the administration from the Department of Health and Human Services, and we agreed that we would reconvene the meeting at 2 o'clock to receive the testimony from our last witness, Dr. Graham, so we are going to recess now until 2 o'clock, and we will convene at that time to receive that additional testimony.

[Whereupon, at 11:20 a.m., the subcommittee recessed to 2 p.m. of the same day.]

AFTER RECESS

Mr. WAXMAN. The meeting of the subcommittee will come back to order. We are meeting this afternoon to receive testimony from Dr. Robert Graham, Health Resources and Services Administration.

STATEMENT OF ROBERT GRAHAM, M.D., ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DANIEL F. WHITESIDE, ASSISTANT SURGEON GENERAL, BUREAU OF HEALTH MAINTENANCE ORGANIZATIONS AND RESOURCES DEVELOPMENT

Dr. GRAHAM. Thank you very much, Mr. Chairman, for the opportunity to appear before you this afternoon. I am accompanied by Dr. Daniel Whiteside, Director of the Bureau of Health Maintenance Organizations and Resources Development, which administers the Federal Health Planning Program.

I would summarize the statement which has been submitted to you and point out it reiterates our opposition to continued Federal support, both in terms of dollar resources and statutory authority for the planning program. We feel this is an inappropriate role for the Federal Government to take, and that the decisions as to whether or not a planning apparatus should be maintained should more appropriately be left to the local communities and the States themselves.

We do point out in that statement that over the past several years there have been an increasing number of areas where successful planning initiatives have been launched by the communities to better address the needs of resources development and distribution as they perceive it, and that these initiatives would not require continued Federal participation.

I think that gives you the substance of our concerns and our feelings about this particular provision, and in the remaining time, Dr. Whiteside and I would be happy to respond to any questions you have.

[The prepared statement of Dr. Graham follows:]

STATEMENT

BY

ROBERT GRAHAM, M.D.

ADMINISTRATOR,

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PUBLIC HEALTH SERVICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and members of the Subcommittee, it is a pleasure to be here today to discuss the Health Planning program authorized by Title XV of the Public Health Service Act. I am accompanied by Dr. Daniel Whiteside, Director of the Bureau of Health Maintenance Organizations and Resources Development, which administers the Federal Health Planning program.

As you know, Mr. Chairman, the Administration has proposed elimination of the Federal Health Planning program since Fiscal Year 1981. The authorization for the Health Planning program expired on September 30, 1982.

Termination of the federally mandated and funded health planning program has been consistent with our plans to develop and carry out health care financing reforms and other measures designed to restrain costs by stimulating competitive forces within the health care system. The health planning authorities represent a costly effort from Washington to impose a complex and burdensome program, basically regulatory in nature, on States and localities and this has not proven to be effective in controlling costs on a national basis. If competitive forces are to restrain costs, free entry into health care markets is essential. Otherwise, high-cost providers can monopolize health care markets. The Certificate of Need review process conducted under the Health Planning program is a system whereby hospitals and other institutional providers must receive a government franchise before beginning or expanding operations. This system inhibits free-market entry, often propping up high-cost institutions behind a government-created entry barrier. Elimination of this franchising system is a necessary element in the Administration's efforts to promote the effective functioning of private market forces in the health care sector.

I would call to your attention, Mr. Chairman, that six States no longer have Certificate of Need programs—Louisiana, Idaho, New Mexico, Utah, Minnesota, and Arizona. Moreover, California has passed legislation to eliminate Certificate of Need by early 1987. We therefore maintain that if Congress were to re-authorize the anti-competitive health planning—CON requirement it would undermine the current successful efforts in the States to reduce health costs without resorting to Certificate of Need. It is clear that this trend in the States provides further recognition that the Federal role in health planning has not worked.

Moreover, with the advent of prospective payment and the desire to control capital costs through the DRG system by October 1, 1986, the need for federally funded State Certificate of Need programs will even be further obviated. We believe the Administration's reforms in Medicare payment provide greater incentives to hospitals to deliver cost-effective quality health care. The Medicare Prospective Payment System (PPS) corrected a fundamental flaw in the old cost-reimbursement system which almost by rote paid hospitals their costs, while PPS for the first time allows Medicare to reward efficiency.

For these reasons, we continue to urge that health planning not be reauthorized. This would not, of course, preclude individual States or localities from continuing to conduct and fund health planning activities which they believe are appropriate to their localities.

Since the inception, of Health Systems Agencies (HSAs), they have been encouraged to accept non-Federal funds, contributed for the benefit of overall health planning activities. The non-Federal support that HSAs have received is worthy of note. It is one indication, we feel, that when Federal support is withdrawn those communities that have found health planning activities valuable will see to it that support is maintained.

- In 1984, non-Federal contributions to HSAs reached their highest level, \$7.8 million. This represents about 26% of the funds that go into local agencies.

Where health planning activities are perceived to meet local needs they would probably be continued. For example:

- In San Diego, the HSA has devoted substantial time and effort to controlling health care costs by functioning as the San Diego business coalition's primary source for data and analytic expertise. Because of this connection between the business coalition and the HSA, it is likely that if Federal support for health planning is terminated, the business community would see to it that this data and analytic expertise were not lost. Presently, 30% of the HSAs budget comes from non-Federal funds.
- The Health Policy Corporation of Iowa is a reconstituted HSA which has replaced its HSA governing board with a coalition of corporate

executives and community leaders in Iowa. This new board is now working with the businesses on cost containment activities and better utilization of existing services. This is an example of where a community has abandoned the Federal requirements and substituted for them a mechanism that meets its own local needs.

In conclusion, we wish to stress that complete withdrawal of Federal support for the Health Planning program is the only acceptable alternative to this Administration. We believe that whatever success the Nation achieves in curbing the growth of health costs will come from structural changes in the marketing and financing of health care, as well as from commitments on the part of businesses and State and local governments to work to slow the increase in health care costs. Thus, we remain steadfast in our opposition to a Federal role in health planning, which we believe leads invariably to costly regulation and second-guessing of what the State and local governments ought to do. Moreover, we think the evidence is strong that where activities can stand on their own merit, non-Federal resources will be made available to ensure their continuation.

Thank you Mr. Chairman. I would be pleased to answer any questions which you and other members of the Subcommittee may have.

Mr. WAXMAN. Thank you. The purpose of the planning program, among other goals, is to try to contain costs by limiting the excess capacity that is paid for and to try to figure out an allocation of resources in a way that not only would contain costs, but provide access to care by people who are not otherwise going to have access to care, particularly the uninsured.

Federal dollars go into Medicare, Medicaid, so we do have a stake in this. What should be the appropriate role of the Federal Government in these decisions we thought a planning program should be addressing?

Dr. GRAHAM. I think it is fairly clear that within the last several years, the perception of the Federal role and strategies we are pursuing have shifted and that the basic strategy that we are pursuing now is to try to assure more equitable distribution of resources, and an appropriate level of access through revising the payment mechanism, so that the institutions have some incentives to decrease the per unit cost of care, and hopefully provide an increase in the capacity of the system to give services to everyone who needs them.

The administration is going from a regulatory to a market-based approach in terms of meeting those objectives.

Mr. WAXMAN. We heard this morning some concerns expressed about the allocation of capital to various hospitals around the country. Without a planning system, the concern was that capital would flow to those hospitals that are going to be available for the fully insured, and that little capital will flow to those with a disproportionate share of Medicaid, Medicare, and indigents.

In fact, the figures were that \$10 billion from capital costs have flowed to one-quarter of the hospitals only. How do we deal with that misallocation of capital, particularly as we look down the road and see those hospitals that take a disproportionate share of publicly insured and uninsured patients needing capital for purposes of expanding or just repairing and remodeling and keeping pace with the needs for their hospital?

Dr. GRAHAM. The issue of capital allocations and capital availability is a highly complex one and is an issue where Dr. White-side's bureau is also involved through their responsibility for the HUD 242 Program. In my view, the simple provision of a certificate of need, as a hurdle or barrier which must be passed for an institution to have the franchise to pursue a capital expenditure, seems to me to be a control point, but not a distribution point.

You only become involved in the certificate of need program at the present time when you are seeking to expend capital. I really do not believe that particular avenue addresses the full scope of questions that you appropriately have raised.

And that is the source of capital, the cost, its distribution, the utilization. We are trying—

Mr. WAXMAN. Let me interrupt you. If you don't have any planning system and it is the marketplace allocating capital, don't you expect the marketplace to allocate the capital to those areas where they stand best opportunity to receive a return on their capital investments?

Dr. GRAHAM. The suggestion which is implicit in our testimony to you is a feeling that mechanisms other than the certificate of

need, a barrier or regulatory mechanism, may be as effective or more effective in the complex area of capital distribution.

Mr. WAXMAN. Let me hear from Dr. Whiteside.

Dr. WHITESIDE. Well, there is going to be a certain amount of, distortion in the marketplace with respect to these hospitals that give care to a disproportionately large number of poor people.

Perhaps local activity would have to be directed to get sufficient capital into those hospitals.

Mr. WAXMAN. For example?

Dr. WHITESIDE. Municipalities, State government.

Mr. WAXMAN. In other words, the burden of the State and local governments to be concerned about the capitalization of hospitals that serve disproportionate share of the poor? And not the Federal Government?

Dr. WHITESIDE. The Federal Government would pay its proportionate share by contributing to Medicaid costs.

Mr. WAXMAN. But Medicaid costs don't reimburse at the same level as private insurers.

If the market were looking for a place to invest their funds for capital, they are not going to want to invest in a hospital that has a heavy Medicaid population.

Dr. WHITESIDE. That is quite true. That is why I think you are going to need State and local funds rather than private capital to finance those hospitals.

Mr. WAXMAN. Do you feel your evaluation of what the efforts are at the State and local levels that they are already moving to meet this need?

Dr. WHITESIDE. I think that varies pretty much across the country, depending—

Mr. WAXMAN. Can you give me an example of the best response by local government to this problem so we can look at it as a model to recommend to others that are not responding as well?

Dr. WHITESIDE. I think that the State of North Carolina is perhaps doing one of the outstanding jobs in attempting to meet the needs of the underserved.

Mr. WAXMAN. What are they doing?

Dr. WHITESIDE. They have set up an office that is concerned with these and other issues, including the distribution of health personnel as well as facilities.

Mr. WAXMAN. Does this office have funds to distribute to those facilities that have a disproportionate share of the poor so they can renovate and build and expand their facilities to meet the growing needs of the poor.

Dr. WHITESIDE. I don't know the answer to that question.

Mr. WAXMAN. Isn't that the kind of question we need to have an answer to before we dump the planning program and not have any Federal responsibility for allocation of the capital?

Dr. WHITESIDE. Certainly.

Mr. WAXMAN. In the prepared statement there is a quotation, if Congress were to reauthorize the anticompetition health planning CON requirement it would undermine the current success efforts in the States to reduce health care costs without resorting to certificate of need.

I thought that was a remarkable statement.

Dr. Whiteside, why do you think its anticompetitive to have a certificate of need? How does that hurt the competition in health care?

Dr. GRAHAM. Mr. Chairman, if I could respond since it is my statement, I think it is unfair to ask Dr. Whiteside to respond to the question, although I am sure he has his views.

Mr. WAXMAN. Let me ask Dr. White side if he agrees with those views.

Dr. GRAHAM. Fair enough.

Dr. WHITESIDE. To a certain extent, I think that the certificate of need program does tend to close out competition and limits other kinds of providers from moving into an area. I think that does indeed occur.

Mr. WAXMAN. In the first 60 days after Utah's CON program was terminated, letters of intent were filed to add 2,800 new nursing home beds, an increase of more than 50 percent over the current total of 4,900 beds.

Of the 4,900 existing beds, 600 are reported to be empty. Tell me how nursing home costs in Utah are going to be contained without a certificate of need, whichever of you wish to respond.

Dr. GRAHAM. Well, I think the fact that one applies for a certificate of need does not necessarily mean that the individual beds will be built or opened. That is one of the difficulties with a franchising system.

If you don't have the franchise, your options are limited. So the first thing that a prudent planner must do is to get the franchise, and then decide whether or not the investment will be realized.

If the data are correct, that of the beds presently available in Utah, some 600 of them are vacant, I think it is fair to ask where are they located, and why are they vacant?

Is there an indication that there is no demand in Utah for that many nursing home beds? I would not presume to tell you I know that answer. I am just responding to the way you posed the question.

Mr. WAXMAN. It is not a hypothetical one. We now have—let me posit to you the way I want you to respond, because I want you to respond to my question. My question is if you have got 4,900 existing beds and they report 600 empty and you don't have a franchising program through certificate of need, and, therefore, they are talking about adding 2,800 more, what does that do to health care costs, a great portion of which will be coming from the Federal Government?

Isn't that going to drive prices up?

Dr. GRAHAM. I will answer your question with a question. Why would you assume so? Who is going to pay for that? Who is going to take the risk of a vast expansion of supply, when the data shows that the beds are not needed? Where will the money come from to build those beds, and who is going to occupy those beds?

If you put your capital in there as an investor or as a private voluntary organization, or whoever is coming forth with these applications, and there is no one to fill those beds because the 600 empty beds indicate the system is already saturated, I don't think those investors or those private voluntary organizations or whom-

ever are the sponsors of those applications are going to be very happy with their decision to build those beds.

Mr. WAXMAN. So you challenge the basic premise that excess capacity costs the health care system more?

Dr. GRAHAM. As we move from a cost-plus reimbursement system to a perspective reimbursement system, I believe the dynamics of what forces an increase in health care costs per unit may well be changing.

Mr. WAXMAN. Shouldn't we abolish health planning once we understand what is happening as a result of DRG rather than before? We may well come to the conclusion we are going to need some kind of health planning under the DRG system when we decide what to do on capital. Why should we abolish the whole thing before we even know where we are going?

Dr. GRAHAM. I think as I indicated in my summary and as we have discussed before, one of the areas where the President has felt most strongly and has made his desires most clear, is that the Federal role in planning is inappropriate, and he does wish to discontinue that, and that has been his proposal since 1981.

Mr. WAXMAN. I wish we had the President right here so we could talk to him about this issue.

Dr. GRAHAM. There would be more people in the room.

Mr. WAXMAN. The First Day hospitals in Arizona were free from the certificate of need, permits were filed to build 831 new beds in Utah, with 37 percent of hospital beds empty, five new hospitals are being built. Is this the competition the administration believes is good for the rest of the country?

Dr. GRAHAM. Again, I believe—let me part your question. I believe it is the administration's position we represent to you today that competition in the health care field is positive and should be pursued.

The specific examples which you have cited are indications to me, that what is going on in those States is a certain type of competition attempting to deal with a rapidly changing set of rules in the health care industry.

Quite frankly, I believe what we will be seeing in the coming years, given the changed mechanisms of payment—and certainly if the concept of prospective payment spreads beyond simply the Federal sector into the private insurers, as is being considered by some of them and implicitly in the HMO industry—will be a greater reluctance on the part of voluntary and for-profit organizations to make capital investments in areas where there may already be an adequate or oversupply of bed stock.

I think what we have seen in the two examples that you have cited is with the expiration of a specific certificate of need barrier. There is very little incentive not to go ahead and build, because you know you are going to be reimbursed for it. Cost-based reimbursement has traditionally resulted in behavior that says, as soon as CON goes away, I want to get in and get my franchise so I can build a hospital.

I believe we should watch very carefully to see what later behavior is as to whether or not those applications are indeed acted upon. What I think I hear from the hospital industry is a heavy

degree of caution about the degree of capital expansion in urban market areas at the present time.

Mr. WAXMAN. Dr. Graham, and Dr. Whiteside—are you a doctor?

Dr. WHITESIDE. Yes. Doctor of dental surgery.

Mr. WAXMAN. You are a “paradox.” That is an old joke. Right?

Dr. GRAHAM. We will get even.

Mr. WAXMAN. You already did with your testimony.

Dr. Graham, your comments about what you see happening in the marketplace, you said I believe this, that and the other. And I know you are here representing the administration and the President's point of view on this subject, as he has looked at it and thought it through.

But since you have raised your personal beliefs, let me ask you, does abolishing the health planning program represent your personal beliefs?

I wouldn't have asked you because you are not representing yourself, but you did raise with us your personal views. I want to know what your personal views are.

Dr. GRAHAM. I think it is appropriate in the context of responding to the substantive question before us to reflect the priorities of the President, which is the purpose for which you have called me and Dr. Whiteside before you today.

Mr. WAXMAN. I guess the dilemma I have is, you speak for the administration. You represent their point of view. But then when you say I personally believe these changes in reimbursements will produce the following results, I think of you as then someone who has been very immersed in health care issues and then I think you are sharing with me your views.

So I am trying to figure out which are your views because I have a very high regard for those, and then which are your views and the administration's views, and wonder which, if they are the same under all the circumstances in which we have had a presentation, or whether we are hearing on the one hand your views personally, on the other hand, the administration and the President's view.

Dr. GRAHAM. That is certainly the complexity which faces all witnesses.

Mr. WAXMAN. That is the complexity for those listening to the testimony elicited. So then I will have to sort that one through and evaluate which of the testimony I think represents your views and take that into consideration and take it quite seriously.

Dr. GRAHAM. Fair enough.

Mr. WAXMAN. The rest we will have to evaluate against other testimony. Of course, we will do that for everything and see what best we can do. Figure out what will be the consequences of some of these recommendations.

Well, we appreciate hearing from the President through you and will look forward to working with the President through you, or others who will be representing him as we try to figure out what to do with health planning.

Thank you for being with us.

Dr. GRAHAM. Thank you.

Mr. WAXMAN. That concludes the business of the subcommittee. We stand adjourned.

[Whereupon, at 2:25 p.m. the subcommittee adjourned, subject to the call of the Chair.]

[The following letters were submitted for the record:]



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JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

May 22, 1985

The Honorable Henry Waxman
Chairman
Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20015

RE: Health Planning

Dear Representative Waxman:

The American Medical Association takes this opportunity to submit its comments concerning health planning as a means of controlling capital expenditures. We request that these comments be made a part of the record of the Subcommittee's hearing held on this subject on May 3.

The AMA has consistently opposed the federal health planning program since its establishment. The most recent formal expression of policy was contained in a resolution approved by the AMA House of Delegates at its June 1983 Annual Meeting:

RESOLVED, that the American Medical Association continue to seek repeal of the National Health Planning and Resources Development Act of 1974, P.L. 93-641, as amended, and until the Act is repealed, to seek a legislative amendment to remove or delay those portions of the Act which impose penalties on states not in compliance with federal certificate of need criteria.

The AMA believes that the overall philosophy behind the health planning program--centralized federal regulatory control over capital expenditures by health facilities for expansion and development--has been discredited as a means of guiding the rational growth of an efficient health care delivery system while at the same time keeping health care cost increases under reasonable control. The program is a relic of a public policy era when it was assumed that federal government regulatory approaches could provide for the rational distribution of health care services and as a consequence appropriately control health care markets and costs.

The health planning program's failures have been demonstrated repeatedly. The program established a nationwide network of "health systems agencies" which, although locally based, became federal instrumentalities charged with carrying out national planning dictates developed in Washington. The concept of local groups having flexibility to determine needs and priorities within their communities, which we consider of great importance, was increasingly ignored as the program developed.

Studies have been conducted to determine the health planning program's impact on health care costs. These studies have failed to produce convincing evidence that the program has succeeded in having a significant impact on controlling health costs. In fact, some studies suggest that the certificate of need process actually results in increased health facility costs due to delays in gaining approval, legal paperwork requirements, and costly appeals of CON decisions.

There is increasing recognition by health care economists that it is through market incentives and enhanced competition that health care costs will be moderated. The health planning program with its certificate of need component is inherently anti-competitive--creating a franchise for existing facilities and erecting barriers to market entry by new facilities.

We are pleased to see affirmation of our views in the following statements presented in the oral testimony at the hearing on May 3rd:

" . . . reauthorization of the existing health planning structure would be redundant or counterproductive, inappropriate, potentially hazardous to the public's health, and a serious obstacle to many hospitals' abilities to serve the needy." (LaRah Payne, Director of Planning, Howard University Hospital, Washington, DC)

"Health planning is the wrong mechanism to control capital expenditures." (Don Schneider, Ph.D., Director, Health Systems Management, School of Management, Rensselaer Polytechnic Institute)

In addition, statements indicating significant problems with the program were made by a coalition of organizations including the American Association of Retired Persons, American Health Planning Association, American Nurses Association, the American Public Health Association, Blue Cross Blue Shield Association, Catholic Health Association, Group Health Association of America, Health Insurance Association of America, National Association of Counties and the National Association of Rehabilitation Facilities. Although this coalition supports reauthorization of the federal health planning program, which AMA does not, the group did make the following statements going to the very core of the federal program:

"The health planning program should be streamlined, minimizing process requirements and allowing state and community flexibility to respond to the changing health care environment.

"The health planning reauthorization should permit voluntary participation, by removing large penalties and allowing states to choose not to join the program."

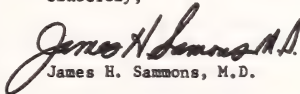
While we oppose the federal health planning program we do not oppose health planning per se. Indeed, the American Medical Association strongly supports voluntary, locally-based health planning and we have developed a series of principles to guide such local planning efforts (enclosed).

The current health planning program perpetuates a system of federal directives which do not meet the goal of locally-based health planning. The program represents an inappropriate combination of regulatory and cost-control functions with health planning functions.

A particularly irksome feature of federal health planning law is contained in the provisions that provide that health maintenance organizations (HMOs) and facilities controlled or leased by HMOs are exempt from most CON requirements. We believe that government preferences to promote further HMO development are no longer necessary. A recent study has found that enrollment in HMOs reached 12.5 million persons in June 1983, a 15.3% increase over the previous year and the largest annual increase since 1978. Moreover, we do not believe that government policy should favor one particular health care delivery mode over another. It should, as much as possible, strive for policy neutrality.

The AMA supports locally based and developed health planning programs. We urge the Subcommittee to support the immediate repeal of the National Health Planning and Resources Development Act.

Sincerely,


James H. Sammons, M.D.

JHS/ss



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STATEMENT ON THE NEED FOR HEALTH PLANNING

My name is Daniel Cantrell, and I am Chairman of the Chicago Commission for Health planning and Resources Development, the governing body of the City of Chicago Health Systems Agency (CHSA). I am also President of the Mile Square Health Center, a community health center serving the West Side of Chicago. I am pleased to have the opportunity to present this statement to the Health and Environment Subcommittee of the Energy and Commerce Committee

The City of Chicago Health Systems Agency supports the continuation of health planning for several reasons. Following are four of the most important.

1. Health planning protects the interests of the community at large, and in particular, the under- and un-insured and the institutions which serve them.

The health care industry is changing more rapidly than ever before. Hospitals and physicians are under increasing financial pressures due to changes in payment systems. These pressures are compelling changes in hospital behavior and creating an atmosphere where institutional self-interest may take precedence over community need. Institutional viability is increasingly dependent upon successful competition for the more lucrative payors. We are concerned that these hospital behavior changes jeopardize

- access to care by the under- and un-insured, who comprise more than one-third of Chicago's population;
- specialty care services, such as burn and neonatal intensive care, which have historically been loss leaders on institutional balance sheets;
- clinical research; and
- educational programs in clinical settings.

In general, urban hospitals have older physical plants, more need of modernization, and less access to competitive capital markets due to their weaker financial positions and poor payor mix. Given that one-third of Chicago's population already experiences financial barriers to access to care, the

Harold Washington
Mayor

F. Daniel Cantrell
Chairperson

Susan L. Weed
Executive Director

collapse of significant portions of the city's hospital system would have disastrous consequences for much of the population.

In short, without health planning, the accessibility, quality, comprehensiveness, and acceptability of our health care system may be threatened.

2. Health planning can design and adjust the capacity of the health care system to appropriately and efficiently meet the needs of the population.

While it may be desirable to introduce additional competitive forces into the health care marketplace, the new "competition" programs fall far short of achieving a competitive market. Medicare's prospective payment/peer review system is, in reality, the most regulatory program ever imposed on hospitals by the federal government. The new "competition" barely involves the consumer. A truly competitive marketplace requires a level of consumer knowledge about price and product and informed decision-making that will require years to achieve. In fact, it is doubtful that we will ever achieve a perfect competitive market in health care, although some competitive forces can help hold down costs. In any case, competition will not design a health care systems appropriate for the needs of all of our citizens.

Too often health planning's non-regulatory roles are overlooked. In implementing plans, health planning has a role influencing policy and resource allocation. Examples of CHSA's advocacy work include

- influencing changes in service areas of (already funded) Title X Family Planning agencies to cover five neighborhoods with highest teen pregnancy and infant mortality rates which have not previously been served;
- influencing placement of National Health Service Corps physicians to neighborhoods demonstrating most severe need;
- advocating change in state Medicaid regulations to allow benefits to be extended to first time pregnant women during the first trimester of pregnancy.

3. Health planning assists in the containment of costs.

Regulation of the capital side of the industry (through Certificate of Need programs) affects the cost structure.

In other words, the effects of capital costs incurred now are felt for years to come. One single example of the effectiveness of Certificate of Need is fresh in our experience: Three hospitals had submitted applications to install extra-corporeal shockwave lithotripters, machines recently approved by the FDA for the non-invasive treatment of kidney stones. Since only one lithotripter was needed, CHSA's committee refused to approve any of the applications, suggesting that the applicants work out a shared service arrangement. The three university medical centers announced just last week that such an agreement had been reached. This shared service arrangement will save Chicago's health care system \$4 million in capital costs and \$1 million per annum in operating costs, and it would have not occurred had not the regulatory process intervened.

4. Health planning represents the only mechanism for assuring citizen input in the development of their health care system.

Especially during this period of rapid change in the health care industry, many Chicagoans are fearful about their continued access to services. They have seen community-based services close in the face of cutbacks and have read newspaper stories about the potential closure of city hospitals. Support for health planning as a rational approach to protecting access while adjusting system capacity is growing.

The City of Chicago Health Systems Agency hereby encourages the members of this Subcommittee, as well as our other representatives, to support the continuation of health planning. Thank you again for the opportunity to present our statement to you.

MEDICAID COMMUNITY CARE WAIVER

TUESDAY, JUNE 25, 1985

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to call, at 9:45 a.m., in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The committee will please come to order.

In 1981, the Congress gave the Secretary of Health and Human Services the authority to allow the States to use Medicaid funds to pay for services that will keep people out of nursing homes and hospitals. This provision is known as the Medicaid Home and Community-Based Services Waiver, or the 2176 waiver.

Here is how the waivers are supposed to work. The States submit applications for waivers on behalf of particular groups: the aged, physically disabled, mentally retarded, mentally ill, or chronically ill children. The Health Care Financing Administration, which administers the 2176 waivers, has 90 days to review the applications to see whether they are consistent with the statutory requirements. If so, the State's waivers are to be approved for 3 years.

The 2176 waiver authority has been extremely popular with the States. As of May 31 of this year, 47 States had submitted 165 waivers and 102 of these applications had been approved. The majority of the approved waivers cover the aged and disabled. As of December 1984, over 60 percent of the approved waivers covered aged and disabled people and nearly half of the approved waivers covered the mentally retarded and developmentally disabled. Six percent of the waivers covered the mentally ill. About 82,000 persons were expected to receive home- and community-based services under all of the approved waivers.

The goal of all of these waivers is to give poor people in need of long-term care the choice of receiving needed care at home or in the community rather than in nursing homes or other institutions. But these waivers also give States the opportunity to explore different ways of delivering long-term care and to learn about the cost of such care in the community.

Given the States' intense interest in the waivers and given this administration's own commitment to opportunity and freedom and family and neighborhood, we had every reason to expect that the administration would aggressively promote the 2176 waiver program. After all, the 2176 waivers give those at risk of institutional care the opportunity of individual freedom from dependency in

nursing homes by allowing them to stay in their own neighborhoods with their own families.

Instead, the administration seems to be committed to strangling the waiver program with Byzantine procedural requirements and ultra-stringent review standards.

Over the past several years, the subcommittee has received numerous reports from State officials and beneficiaries that HCFA, or the Health Care Financing Administration, prodded by the Office of Management and Budget, has gradually tightened the standards for approval of waivers. The administration's coup de grace was the publication on March 13 of this year of final regulations purporting to implement section 2176.

For an administration committed to deregulation and increased State flexibility, this is an amazing document. In the 16 single-spaced, three-column pages in the Federal Register, plus another page of corrections, HCFA and OMB have constructed a regulatory maze that is unworkable in its detail and complexity. These regulations give new meaning to the word "onerous." This would all be humorous if it did not have such tragic consequences for the frail and disabled poor who need these services to avoid being placed in institutions.

Unfortunately, it is in character with the administration's unrelenting attack on the Medicaid Program and those among us who need its services. Just this past February, the President once again sent us a budget calling for an end to the Medicaid entitlement and a \$17 billion cut in the program over the next 5 years. The administration's philosophy of "spend less, do less, except in military matters," has also found its way into this waiver program.

The program that Congress enacted 4 years ago was specifically designed to be budget neutral. The statute contains safeguards to assure that the waiver does not result in excessive costs, but the waiver was not intended to save money. If States are able to design programs that save money, that is good news, but Congress did not require the States to do so.

The Congress wanted only to assure that the States would not spend more under their waiver programs than they would have paid for institutional care for the population at risk. The March 13 regulations, however, go well beyond assuring budget neutrality. Their overall effect is to require States to show that each year they will spend less money than they would have under their regular Medicaid programs.

The purpose of this hearing is to find out what problems the March 13 regulations create for State efforts to give vulnerable individuals the choice of receiving needed care in the community rather than in nursing homes. We also want to learn why the administration is trying to snuff out the opportunity that the waiver offers for beneficiaries to remain at home with their families.

Finally, we want to learn why an administration which refuses to bring a long-term care reform proposal of its own to the Congress is trying to stymie State efforts to test new ways of delivering long-term care services in the community. The Congressional Re-

search Service has prepared an excellent summary of the 2176 waiver program for the subcommittee, and, without objection, I would like to insert this document into the record at this point.

[Testimony resumes on p. 172.]

[The document referred to follows:]



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MEDICAID "2176" WAIVERS FOR HOME AND
COMMUNITY-BASED CARE

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June 21, 1985

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MEDICAID "2176" WAIVERS FOR HOME AND COMMUNITY-BASED CARE

I. EXECUTIVE SUMMARY

Public programs currently provide more support for institutional forms of long term care for chronically ill or disabled persons, primarily through the Medicaid program, than for home and community-based care. Over the past decade a great deal of research and demonstration effort has been devoted to demonstrating cost effective and appropriate forms of community-based services targeted to individuals who would otherwise be cared for in more expensive institutional settings. While these demonstration efforts have not yet resulted in major structural changes in the way in which community-based care is organized and financed through Federal programs, a significant provision amending the Medicaid program was enacted during the 97th Congress to alter the perceived bias in the program toward providing and financing institutional care.

The Medicaid Home and Community-Based Services Program, also referred to as the "2176 waiver program," was authorized under Section 2176 of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (P.L. 97-35, enacted August 13, 1981). The legislation allows the Secretary of Health and Human Services (HHS) to waive certain Medicaid requirements to allow States to provide a variety of home and community-based long term care services to individuals who would otherwise require the level of care provided in a skilled nursing facility (SNF) or intermediate care facility (ICF). Although certain home and community-based services were available through Medicaid prior to the amendment,

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the 1981 legislation provides States with increased flexibility to offer an expanded range of such services, to determine individuals to be covered, and to define the geographic areas to be served.

Under the 2176 authority, the Health Care Financing Administration (HCFA), the HHS agency which administers the Medicaid program, is allowed to waive two specific Medicaid requirements: (1) a requirement that Medicaid services be available throughout a State and (2) a requirement that covered services be equal in amount, duration, and scope for certain Medicaid recipients. By allowing the Secretary to waive these requirements, States are given flexibility to offer selected 2176 home and community-based services in only a portion of the State, rather than in all geographic jurisdictions as would be required absent the waiver, and to offer selected services to certain State-defined individuals eligible for Medicaid assistance, including the aged, blind, disabled, mentally retarded, and mentally ill, rather than offering such services to all persons in particular groups. In addition, States have been able to extend to waiver participants the more liberal Medicaid income eligibility rules that may be applied to persons in institutions.

The expanded services which States may offer under an approved waiver include medical and medical-related services as well as social services. Prior to the implementation of the 2176 waiver program, Medicaid services available to chronically ill or disabled individuals living in the community were generally restricted to medical and medical-related services. 1/

1/ The Medicaid statute requires States to provide home health care services to persons eligible for skilled nursing facility services; under certain circumstances, States may also provide other community-based long term care services, such as adult day health and personal care services. Other services of assistance to chronically ill or disabled persons in the community covered by Medicaid include physical, occupational, and speech therapy, and medical supplies and equipment. For further information on the Medicaid program, see CRS Report, "Medicaid: Legislative History, Program Description, and Major Issues" by Jennifer O'Sullivan, Report No. 84-140 EPW, July 24, 1984.

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The waiver authority acknowledges that a wide variety of services may be needed in order to prevent institutionalization. For this reason, services traditionally considered to be social services were covered in the waiver authority. These include case management (commonly understood to be a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization), homemaker and chore services, adult day health, and respite care.

The additional flexibility Congress authorized under the waiver as to services, eligibility, and geographic areas to be covered was qualified by a concern about the costs of home and community-based care to be provided under the amendment. Therefore, the law included a requirement that States demonstrate that the costs of services for individuals receiving home and community-based services not exceed the cost to Medicaid of care in institutions.

The principal changes made by the waiver program can be summarized as follows:

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Medicaid Requirements

Medicaid Waiver Program

"Statewideness"

Services covered under a State's plan must be available throughout the State.

Services may be targeted to State-selected geographic areas.

Long-Term Care ServicesRequired:

- ° Skilled nursing facility
- ° Home health services for persons entitled to skilled nursing facility services.

May include a wide range of services: case management, homemaker, home health aide, personal care, adult day health, habilitation, respite, and other services defined by the State and approved by HHS.

Allowed:

- ° Intermediate care facility services
- ° Personal care, adult day health under certain circumstances.

Eligibility

Must meet Medicaid income eligibility requirements, except that higher income levels may apply to persons in institutions.

Expanded to include persons with higher income levels living in the community.

Costs of Services

No budget ceiling.

Home and community-based services for individuals under the waiver must not exceed the cost of care in institutions.

Under the waiver authority, States are providing a broad range of community-based services to Medicaid eligible individuals who would otherwise require nursing home care. Groups covered under approved 2176 waivers include (1) the aged and disabled, (2) the mentally retarded and developmentally disabled, and (3) the chronically mentally ill.

In addition, a separate category of 2176 waivers, known as model waivers, was created by HCFA to facilitate State efforts to provide community-based services to individuals who are considered to be inappropriately institutionalized as a result of income eligibility rules of the Supplemental Security Income (SSI) program. These rules prohibit individuals who are living at home from receiving SSI, and therefore in most States automatic Medicaid coverage, because the income and resources of a spouse or parents are considered to be available or "deemed" to the individual. Coverage under model waivers is limited to no more than 50 blind and/or disabled children and adults who would otherwise be ineligible for Medicaid while living at home because of these SSI deeming rules.

The target population served under model waivers is similar to that served under another waiver authority established by section 134 of the Tax Equity and Fiscal Responsibility Act of 1982. This provision, known as the Katie Beckett provision, allows States, at their option, to extend Medicaid eligibility to certain disabled children under 18 who are living at home and who would be eligible for SSI if they were institutionalized. States electing this option are required to cover all disabled children throughout the State if these children are assessed to meet certain criteria. (Under the model waiver, States may target services on specific individuals and are not required to cover all eligible persons throughout the State.)

As of April 30, 1985, HCFA had approved 95 home and community-based services waivers in 46 States; 50 waivers were targeted to the aged/disabled;

39 waivers to the mentally retarded/developmentally disabled; and 4 waivers to the mentally ill. In addition, 17 model waivers, predominantly serving children, had been approved. Services most frequently offered under waiver programs (excluding model waivers) are case management (66 waivers), respite care (52 waivers) and adult day health services (43 waivers). Specific information on approved waivers, by State, service offered, and eligibility group are presented in part V of this report.

A 2176 waiver is effective for a period of three years. The Secretary is required to extend the waiver for additional three year periods unless the Secretary has determined that the State has not met various assurances required by law. A State's request for a waiver is deemed to be granted within 90 days after its submission to the Secretary unless the Secretary provides a written denial to the State or requests additional information from the State. If the Secretary requires additional information, the waiver request is deemed to be approved within 90 days of receipt of such additional information unless the Secretary denies the waiver request.

Interim implementing regulations for 2176 waivers were published by HCFA October 1, 1981. Final regulations, with amendments to the interim regulations, were published March 13, 1985. A number of issues, questions, and concerns have arisen since implementation of the waiver, including HCFA review of States' data on costs of their waiver programs, complexity and burden of the approval process, definition of services covered under a waiver request, and reporting requirements. It should be noted that most of the current waiver programs were approved under the interim regulations. Therefore, other issues may be raised as States seek to renew their waivers or apply for new waivers under the final regulations. HCFA has funded evaluations of the waiver program; however, results of these evaluations have not yet been published.

This report presents background on the 2176 home and community-based waiver program, including legislative history, a summary of implementing regulations, an overview of types of waivers granted, and case examples of waivers.

II. LEGISLATIVE HISTORY AND AUTHORIZING LEGISLATION

A. Legislative History

The 2176 waiver program legislation was in large measure based on legislation which had been introduced in the 96th Congress by Congressman Pepper and Congressman Waxman, the Medicaid Community Care Act of 1980. ^{2/} The purpose of that legislation was, in part, to readjust a perceived bias toward institutional care under the Medicaid program by expanding the range of community-based long term care services eligible for reimbursement, thereby allowing persons to be cared for at home and by families. The bill would have also expanded the pool of eligible individuals by allowing States to apply the same income and resource standards used for determining eligibility for nursing home care to persons using community-based services. (Medicaid allows States to apply certain more liberal standards to the institutionalized.)

^{2/} The Medicaid Community Care Act of 1980 (H.R. 6194), introduced on December 19, 1979, would have broadened Medicaid coverage of home and community-based services by increasing Federal matching funds for such services by 25 percent, or by setting the Federal medical assistance percentage for such services at 90 percent. States would have been required to provide a comprehensive medical and social assessment of individuals likely to be in need of skilled nursing facility or intermediate care facility services and to inform persons in need of institutionalization about the availability of community-based services. Services eligible for reimbursement included those listed in the Section 2176 legislation as well as nursing services, nutrition counseling, and medical supplies and equipment. States would have been required to establish minimum and maximum reimbursement rates for services. H.R. 6194 also included language explicitly expanding the pool of eligible individuals by allowing the State to elect to apply the same income and resource standards used for determining eligibility for nursing home care to persons using community-based services. The program would have been developed at State option.

The final provisions of the enacted Section 2176 legislation were the product of the House and Senate budget reconciliation bills considered during 1981. ^{3/} The Senate bill allowed the Secretary to waive the definition of covered services to include as medical assistance certain non-medical services (excluding room and board) approved by the Secretary. Services could include case management, supervised living, personal care, home services, and rehabilitation. It required that services be provided under a plan of care to persons who, but for such services, would require institutionalization which could be reimbursed under the State's Medicaid plan. It also prohibited the Secretary from granting a waiver unless the State provided assurances that necessary safeguards were taken to protect the health and welfare of recipients. It should be noted that the Senate's bill also proposed an overall limitation on Federal Medicaid expenditures, sometimes referred to as a cap.

The House bill allowed States to apply to the Secretary for approval of a State community care plan under which States would provide comprehensive assessments of individuals eligible or applying for assistance for SNF or ICF services, and to consider medical and social factors relating to the need for institutionalization. The bill also provided for a range of services not otherwise available under Medicaid, including case management, nursing services, home-maker/home health aide and personal care, medical supplies, equipment and appliances in the home, therapies, adult day health and habilitation, respite care, and other services approved by the Secretary. Services were to be provided without limitation as to amount, duration, or scope. In order to assure budget neutrality, the House provision required States to provide that the

^{3/} Section 6329 of H.R. 3982; and Section 730 of S. 1377. See Attachment C for House and Senate bill and report language.

community care plan would not result in expenditures for institutional and non-institutional care above the level of expenditures if the community care plan were not approved. States could also establish a dollar limit on the total amount of medical assistance provided in a 12 month period.

In the reports accompanying their respective bills, the House Energy and Commerce and the Senate Finance Committees both recognized the need for expanded availability under Medicaid of certain services which could postpone or prevent institutionalization. The Senate report indicated that some services "while not strictly medical in nature may in fact contribute to improved health, and could potentially postpone or prevent institutionalization. To the extent that institutionalization is deferred or avoided, certain costs savings may result." ^{4/} The House report pointed out that many disabled or chronically ill or disabled persons "live in institutions, not for medical reasons, but because of the paucity of health and social services in their communities, and their inability to pay for those services or to have them covered by Medicaid when they do exist." ^{5/} Both bills targeted the expanded services on persons who would otherwise require institutional care.

^{4/} U.S. Senate, Committee on the Budget. Omnibus Budget Reconciliation Act of 1981. Report to accompany S. 1377. Report No. 97-139, June 17, 1981. 97th Congress, 1st Session, p. 481.

^{5/} U.S. House of Representatives, Committee on the Budget. Omnibus Budget Reconciliation Act of 1981. Report to accompany H.R. 3982. Report No. 97-158, Vol II, June 19, 1981. 97th Congress, 1st Session, p. 316.

B. Authorizing Legislation

Section 2176 of P.L. 97-35 amended the Medicaid statute (title XIX of the Social Security Act) by adding a new subsection 1915(c) to authorize the Secretary to allow States to provide under their State Medicaid plans a variety of home and community-based long term care services to individuals who, but for the provision of these services, would require institutional care whose cost could be reimbursed under the State's Medicaid plan. (The full text of the law and conference report language is included as Attachment A.) The provision authorizes coverage for the following services: case management, homemaker/home health aide, personal care, adult day health, habilitation, and respite care. Other services may be requested by the State and approved by the Secretary. Room and board are excluded from coverage under the waiver. Services must be provided to individuals eligible for the program pursuant to a written plan of care.

The legislation allows the Secretary to waive the following statutory provisions: Section 1902 (a)(1) which requires that services offered under a State's Medicaid plan be available on a Statewide basis; and Section 1902 (a)(10) which requires that services available to "categorically needy" Medicaid beneficiaries are not less in amount, duration and scope than services available to "medically needy" beneficiaries and are equal in amount, duration,

and scope for all "categorically needy" beneficiaries. 6/ By allowing the Secretary to waive these requirements, States are given flexibility to offer selected 2176 home and community-based services in only a portion of the State, rather than in all geographic jurisdictions as would be required absent the waiver, and to certain State-defined individuals eligible for Medicaid, including the aged, blind, disabled, mentally retarded, mentally ill. The law also allows the State to limit coverage to individuals for whom the State has determined there is a reasonable expectation that the cost of services provided will not exceed the amount of medical assistance for such individuals in the absence of the waiver.

In order to receive approval for a waiver, the States must provide satisfactory assurances to the Secretary that:

- ° necessary safeguards have been taken to protect the health and welfare of individuals provided services under the waiver. Such safeguards must also assure financial accountability for expended funds, and adequate standards for provider participation;
- ° the State will evaluate the need for waived services on the part of individuals who are eligible for and require Medicaid SNF or ICF services;
- ° individuals who are determined likely to require SNF or ICF services

6/ Medicaid law requires that States cover under their programs the "categorically needy"--all persons receiving assistance under the Aid to Families with Dependent Children (AFDC) program and most aged, blind, and disabled persons receiving assistance under the SSI program. States may also cover additional persons as categorically needy. These might include persons who would be eligible for cash assistance, except that they are residents in medical institutions, such as skilled nursing or intermediate care facilities. In addition to the categorically needy, States may at their option cover the "medically needy," persons whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but not large enough to pay for medical care. If the income and resources of the "medically needy" individual are above a State-prescribed level, the individual must first incur a certain amount of medical expense which lowers the income to the medically needy levels (so-called "spend-down" requirement).

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are informed about the availability of waived home and community based services and are given the choice of using these services or institutional services;

- the average per capita expenditure for medical assistance for individuals under the program estimated by the State in any fiscal year will not exceed the average per capita expenditure that the State reasonably estimates would have been incurred in that year for expenditures under the State plan for such individuals if the waiver had not been granted;

- the State will provide to the Secretary annually information on the impact of the waiver on the type and amount of medical assistance under the State plan and on the health and welfare of the recipients.

The waiver is effective for a period of three years. The Secretary is required to extend the waiver for additional three year periods unless the Secretary determines that the State has not met the required assurances. Section 2177 of OBRA further requires that a State's request for a waiver is deemed to be granted within 90 days after its submission to the Secretary unless the Secretary provides a written denial to the State or requests additional information from the State. If the Secretary requires additional information, the waiver request is deemed to be approved within 90 days of receipt of such additional information unless the Secretary denies the waiver request.

The conference bill report on Section 2176 of OBRA included the following points:

- States must determine that individuals would otherwise need institutional care based on an evaluation which takes into consideration both medical and non-medical factors;

° States must determine that it is reasonable to provide individuals with alternative services pursuant to a plan of care while preserving patient choice. The report indicates that the determination of which long term care options are feasible in a particular instance should be based on the individual's needs, as determined by an evaluation, and not on short-term cost savings: "While the conferees anticipate that the provision of community-based care will have a long range and significant impact on the size of States' Medicaid budgets, they do not believe that States should make decisions regarding the feasibility of community-based care on the basis of whether or not such arrangements will produce short-term cost savings."

° States must provide for the formulation of a written plan of care for waived services.

° States must determine that alternative services will not result in overall expenditures in excess of what would be incurred if the individual were institutionalized. Specific services mentioned by the report to be included in the State's estimate of Medicaid expenditures, in addition to SNF or ICF costs, are physician visits, hospitalization, and prescription drugs. In addition the total of all medical assistance for persons provided services under the waiver may not exceed, on an average per capita basis, the total expenditures for these individuals if they were institutionalized. The report provided direction as to how per capita costs should be determined: the costs of medical assistance for community-based care recipients will be divided by the number of individuals who are determined likely to be institutionalized without these services.

° States may set limitations on the amount, duration, and scope of services for individuals served under the waiver which may vary from those provided to other Medicaid recipients. The report cautions that it may be inadvisable to set limitations on each service since the written plan of care for each client would delineate the number and frequency of services, and the State may establish a per capita ceiling on the total cost of each client's care.

It should be noted that Congress included in section 137 of the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248, a provision intended to make explicit Congressional intent that States may cover under their home and community-based waiver programs those individuals who would otherwise be eligible under a higher income standard if they were institutionalized and would require the level of care provided in that institution.

III. "MODEL" HOME AND COMMUNITY-BASED WAIVERS

As noted in a previous section of this report, a separate category of 2176 waivers, known as model waivers, was created by HCFA to facilitate State efforts to provide community-based services to a limited number of blind and disabled individuals who are inappropriately institutionalized due to the application of certain income eligibility requirements of the Supplemental Security Income (SSI) program. Coverage under the model waiver is limited to no more than 50 blind and disabled children and adults who would otherwise be ineligible for Medicaid while living at home because of SSI "deeming" rules.

An individual is eligible for SSI payments, and therefore automatic Medicaid eligibility, if his or her income and resources are below established limits. In making this determination, the total income and resources of the applicant's spouse or applicant's parent, in the case of a child under 18, are automatically considered available, i.e., "deemed" to the individual. However, the "deeming" provisions only apply to individuals living in the same household as their parents or spouse. Under SSI deeming rules, an institutionalized individual is no longer considered to be living in the same household as his/her parents or spouse after the first full month of institutionalization. Therefore, after the first month, only the income actually contributed by the parents or spouse of the institutionalized person is considered.

A person may be eligible for SSI payments, and therefore in most States automatic Medicaid coverage, while institutionalized. However, the same person may not be eligible for SSI, and in most States automatic Medicaid coverage, when living at home because of SSI deeming rules. To obtain or retain SSI and

Medicaid eligibility, some individuals remain in the institution though their medical needs could be taken care of at home. This situation was dramatized by the case of Katie Beckett. Katie Beckett was an institutionalized child who was unable to go home because she would no longer be eligible for SSI and therefore Medicaid because the income of her parents was deemed available to her. The case received national attention and the President intervened in her behalf.

Both the Department of Health and Human Services and the Congress instituted measures to deal with situations similar to those of Katie Beckett. In 1982, the Department established a Board (composed of the Surgeon General, a HCFA representative, and the HHS General Counsel) to determine whether the so-called SSI deeming rules should be waived in individual instances both for adults and for children. Final implementing regulations, issued February 15, 1984, specified that in each case the Board must find that: 1) prospective savings to the Medicaid program would result, and 2) the quality of medical care will be comparable to that available in the institution. The Board was set up on an interim basis. The last date applications could be submitted was December 31, 1984. Since its inception, the Board has received 290 waiver applications. As of June 15, 1985, 189 applications have been approved, 40 have been withdrawn, 20 are awaiting action by the Board, and 49 are pending (generally with requests for additional information from the States). Approvals remain in effect unless revised based on a review for changed circumstances.

The Department indicated, in the preamble accompanying the February 15, 1984 regulations, its expectation that Board review was expected to offer an interim solution to deeming problems and that States would deal with special situations involving the disabled under either the related provision of the

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Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) or the 2176 home and community-based services waiver authority.

Section 134 of the TEFRA of 1982 added a provision which allows States, at their option, to extend Medicaid to certain disabled children under 18 who are living at home and who would be eligible for SSI if they were institutionalized. The State must determine that 1) the child required the level of care provided in an institution; 2) it is appropriate to provide such care outside of the facility; and 3) the cost of care at home is no more than institutional care. States electing this option are required to cover on a Statewide basis all disabled children meeting these criteria. This provision is sometimes referred to as the Katie Beckett provision. As of June 14, 1985, the following jurisdictions have established programs for such individuals: Arkansas, Georgia, Idaho, Maine, Nevada, Rhode Island, Wisconsin, and Northern Mariana Islands.

IV. SUMMARY OF IMPLEMENTING REGULATIONS

Interim implementing regulations for 2176 waivers were published by the Health Care Financing Administration (HCFA) October 1, 1981. Final regulations, with amendments to the interim regulations, were published March 13, 1985. It should be noted that prior to the publication of the final regulations, States were subject to informational requirements which were different from those imposed by the interim regulations and which changed over the period. The following discussion summarizes major provisions of the waiver regulations. The complete interim and final regulations as published in the Federal Register, together with their explanatory preambles, appear in Attachment B.

A. Definition of Services

The regulations provide that home or community-based services for which a waiver may be granted may include the following (other than room and board):

1. Case management services.
2. Homemaker services.
3. Home health aide services.
4. Personal care services.
5. Adult day health services.
6. Habilitation services.
7. Respite care services.
8. Other services requested by the State and approved by the Secretary.

Both preambles to the interim and final regulations indicate that HCFA does not believe it appropriate to mandate definitions for these services. In addition, HCFA believes that States are free to include a wide range of services in their programs -- hospice services, home adaptations to increase

safety, nutritional assessment, counseling, etc. However, in the final regulations HCFA provided a policy clarification prohibiting States to offer pre-vocational and vocational training under their waiver programs. HCFA notes that the law does not restrict the coverage of appropriate services as long as the State: (1) demonstrates that the services are cost-effective; (2) demonstrates that the services are necessary to avoid insitutionalization; (3) includes and defines the services in its waiver request; and (4) obtains HCFA approval.

B. Waiver Request Requirements

Among other things, a waiver request must describe the services to be provided under the waiver and the group or groups of individuals to whom services will be offered. The request must be limited to one of the following targeted groups or any subgroup of one of these groups that the State may define: the aged or disabled or both; the mentally retarded or developmentally disabled or both; or the mentally ill. Furthermore, services can only be furnished to those eligible beneficiaries who, but for the provision of home and community-based services, would require the level of care provided in a SNF, ICF, or ICF/MR.

The waiver request must also provide that services will be furnished under a written plan of care and must describe the qualifications of individuals responsible for developing the plans of care. The preamble to the interim regulations elaborates that States have discretion in designing the plan of care process and prescribing who writes individual plans of care. HCFA expects the plan of care to include the medical and other services to be provided, their frequency, and the type of provider furnishing them. Plans of care are subject

to the State's approval, and the State has the discretion to set up its own approval process.

The waiver request must also contain State assurances and supporting documentation described below.

C. State Assurances

The regulations indicate that HCFA will not grant a waiver, and may terminate a waiver, unless the State Medicaid agency provides the following satisfactory assurances to the Secretary:

1. Health and Welfare

Assurances must be provided that necessary safeguards have been taken to protect the health and welfare of the recipients of these services. Safeguards must include adequate standards for all types of providers that furnish services under the waiver as well as standards for board and care homes where a significant number of Supplemental Security Income (SSI) recipients are residing or are likely to reside and where home and community-based services may be provided. If the State has licensure or certification requirements for any services or for individuals who furnish these services under the waiver, it must assure HCFA that the standards in the licensure or certification requirements will be met. The preamble to the interim regulations points out that the regulations do not attempt to define these safeguards or to prescribe how they are to be developed. Rather they leave to the State the responsibility for determining what the necessary safeguards are, to define them or specify how they will be developed and implemented, and to explain how they satisfy the statute.

2. Financial Accountability

The State Medicaid agency must assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program, and maintain and make available to HHS, the Comptroller General, or their designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

3. Evaluation of Need

States must provide for an evaluation (and periodic reevaluations) of the need for the level of care provided in a SNF, ICF, or ICF/MR, when there is a reasonable indication that individuals entitled to institutional services might need such services in the near future.

4. Informing Beneficiaries of Choice

Beneficiaries determined to be likely to require SNF, ICF, or ICF/MR level of care, or their legal representatives, must be informed of any feasible alternatives available under the waiver and given a choice of either institutional or home and community-based services. A beneficiary who is not given the choice of home or community-based services as an alternative to SNF or ICF services may request a fair hearing, unless the reason for the denial is that the group of which the individual is a part is not included within the scope of the waiver.

5. Expenditures

States must provide assurance that the average per capita fiscal year expenditures under the waiver will not exceed the average per capita

expenditures for the level of care provided in a SNF, ICF, or ICF/MR that would be incurred in the absence of the waivers. These expenditures must be reasonably estimated by the State Medicaid agency and the estimates must be annualized and cover each year of the waiver period.

States must also provide assurance that the actual total expenditures for home and community-based services under the waiver will not exceed the State's approved estimated expenditures and that the State will not claim Federal matching payments for expenditures exceeding the approved estimate. (Other regulations specify that Federal matching payments will be available only up to the State's approved estimate of total expenditures for home and community-based services under the waiver.)

In addition, States must assure that actual aggregate Medicaid expenditures for all services provided to individuals under the waiver will not, in any year of the waiver period, exceed the aggregate Medicaid expenditures that would be incurred for these individuals in the absence of the waiver. This assurance has been added by the final regulations. The preamble to the final regulations states that aggregate Medicaid expenditures include payments not only for home and community-based services but also for physician services, acute hospital services, dental care, and pharmaceutical services. HCFA indicates that this assurance has been added as the result of comments and findings that certain acute care services may be provided more frequently or with greater intensity to individuals in the home and community setting than to those in the institutional setting and "to the extent that this occurs, the home and community-based services would be less cost-effective than the estimates shown."

6. Reporting

States must provide HCFA annually with information on the impact of the waiver. The information must be consistent with a data collection plan designed by HCFA and must address the waiver's impact on the type, amount, and cost of services provided under the State's plan and the health and welfare of recipients.

D. Supporting Documentation

The regulations require that the State Medicaid agency furnish HCFA with sufficient information to support the State's assurances necessary for approval of a waiver. This information must include the following at a minimum:

1. A description of the safeguards necessary to protect the health and welfare of recipients, including a copy of standards established by the State for board and care homes in which a significant number of SSI recipients are residing or are likely to reside;
2. A description of the records and information that will be maintained to support financial accountability;
3. A description of the State's plan for the evaluation and reevaluation of recipients including a description of who will make these evaluations and how they will be made, a copy of the evaluation instrument to be used, the State's procedure to ensure the maintenance of written documentation on all evaluations and reevaluations, and the State's procedure to ensure reevaluations of need at regular intervals;
4. A description of the State's plan for informing eligible recipients of the feasible alternatives available under the waiver and allowing recipients to choose either institutional services or home and community-based services; and

5. An explanation of how the State will treat the income and resources of those individuals who are eligible under a special income level for home and community-based services.

E. Documentation of Waiver Expenditures

The regulations require States to provide an explanation, with supporting documentation satisfactory to HCFA, of how the State's Medicaid agency estimated per capita expenditures for services. As noted above, the annual average per capita expenditure estimate of the cost of home and community-based and other Medicaid services under the waivers can not exceed the annual average per capita expenditures of the cost of services in the absence of a waiver. The estimates for this calculation must be based on an equation published in the final regulations (see Attachment B).

In addition, the final regulations require States to provide supporting documentation on the estimated utilization rates and costs for services included in the plan, the number of actual and projected beds in Medicaid certified SNFs, ICFs, and ICFs/MR by type, and evidence of the need for additional bed capacity in the absence of the waiver. The preamble to the final regulations states that "evidence of bed capacity is such an integral part of a Medicaid agency's explanation of estimated per capita expenditures that no waiver request would be sufficient without this documentation,"

The preamble adds that States proposing a waiver population which would exceed the capacity of presently certified beds must produce viable certificates of need and other documentation that beds would actually be built (or have been built) and would be certified absent the waiver. Where the certificate of need process is no longer in effect or no longer viable the State must provide other convincing data that construction would actually take place or

evidence of State appropriations activity. States must also provide data that show the occupancy rates for the beds in their Medicaid certified SNFs, ICFs, and ICF/MRs by type; whether there is any excess bed capacity for these facilities by type; and if so, the number of excess beds. If the State has waiting lists for admission to these facilities, it must provide data that show the number of persons awaiting admission to each type of facility. The State must also show how long people have to wait for admission from the time they are placed on the list.

The final regulations also require States to specify the number of waiver clients actually being deinstitutionalized from certified facilities as compared with those diverted from admission. Where individuals are diverted, States must provide a more detailed description of their evaluation and screening procedures to assure that waiver services will be limited to persons who would otherwise receive the level of care provided in a SNF, ICF, or ICF/MR. The preamble to the final regulations specifies that States must also indicate where the diverted individuals will be coming from and how many will come from each location, e.g., hospital patients awaiting SNF or ICF, or persons at home, in order for HCFA to determine whether the State's estimates are reasonable.

F. Eligibility of Beneficiaries

Under Medicaid regulations, it is possible for a beneficiary who would not be eligible for Medicaid while in the community to be eligible in an institution due to more liberal income eligibility rules applicable to institutionalized persons. States are permitted to set a special income standard that results in a higher institutional eligibility level for institutionalized beneficiaries than would be applied to persons in the community. This special

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income standard, known as the 300 percent rule, can be no higher than 300 percent of the SSI payment standard for persons living in the community. The final waiver regulations extend the more liberal income eligibility rules to waiver participants by allowing States to cover individuals who would be Medicaid eligible if institutionalized (at a higher income standard) and who, but for the provision of home and community-based services, would require SNF, ICF, or ICF/MR care. The waiver regulations also require beneficiaries who are eligible for home and community-based services as a result of a higher income standard to share in the cost of the services. Their income, after deductions of specified amounts (for individual maintenance needs, maintenance needs of spouse and/or family, and incurred medical expenses, as these terms are defined in regulations), is to be applied to the cost of home and community-based care.

G. Duration of Waivers

The effective date for a waiver is established by HCFA prospectively on or after the date of approval, and after consultation with the State. Each waiver continues for a three-year period from the effective date. If the State requests, the waiver must be extended for additional three-year periods if HCFA's review of the prior period shows that the required assurances were met.

If HCFA determines that the State is not meeting any of the requirements for waivers after a notice of findings and an opportunity to rebut HCFA's findings at a hearing, the waiver may be terminated. For example, if HCFA finds that the State's actual total expenditures for home and community-based services under the waiver exceed the agency's approved estimates for these services, for any year of the waiver period, the waiver may be terminated. Similarly, the waiver may be terminated if HCFA finds that the State's actual

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total expenditures for all Medicaid services provided to individuals under the waiver exceed, for any year of the waiver period, the amount that would be incurred by these individuals in a SNF, ICF, or ICF/MR in the absence of the waiver.

H. Independent Assessments

Except as HCFA may otherwise specify for particular waivers, the State Medicaid agency must provide for an independent assessment of its waivers which evaluates the quality of care provided, access to care, and cost effectiveness. The results of this assessment must be submitted to HCFA at least 90 days prior to the end of the three-year waiver period and must cover at least the first 24 months of the waiver.

V. DATA ON STATE WAIVER PROGRAMS

As of April 30, 1985, HCFA had approved 95 home and community-based services waivers in 46 States (36 waivers requests were pending, 14 had been withdrawn, and 22 were disapproved). ^{7/} Of the total number of waivers, 17 are model waivers, a separate category of 2176 waivers created by HCFA to facilitate State efforts to provide community-based services to a limited number (not more than 50) of blind and disabled individuals.

Table 1-1 and 1-2 and Table 2-1 and 2-2 below describe approved waivers by State, services offered, and eligibility group covered as of April 30, 1985 (for the regular 2176 waiver program and the model waiver program). This information has been extracted from a summary description of 2176 waiver requests published monthly by HCFA. Tables 3 and 4 present summary data on waivers and services offered.

As pointed out earlier, States have been given wide latitude in supporting a variety of services under their waiver packages. Because of the legislative requirement that States provide for an evaluation of an individual's need for community-based services, the service most frequently offered under the waivers is case management. Thirty-one States offered case management to aged/disabled individuals covered under waiver programs and thirty States offered this service to mentally retarded/developmentally disabled persons

^{7/} Health Care Financing Administration, Medicaid Waiver Fact Sheet, as of 5/31/85. A review of the HCFA monthly waiver report appears to indicate that the number of approved waivers includes some waivers which have expired.

(see Table 3). Of the 95 waiver programs approved as of April 30, 1985, almost 70 percent, or 66 programs, offered case management (see Table 4).

Besides case management, the most frequently offered services to the aged/disabled are homemaker services (26 States), adult day health care (26 States), and respite care (24 States). Respite services provide short-term relief for care-givers. Chief services offered to the mentally retarded/developmentally disabled are habilitation (31 States) and respite services (25 States). Generally habilitation services refer to health and social services needed to insure optimal functioning of the mentally retarded or persons with related conditions.

While the seven services listed in the regulations are those most frequently offered by States, it should be noted that States have taken advantage of the waiver flexibility by offering services which have not traditionally been supported through the Medicaid program, but could be supported by major social services programs, chiefly the Title XX Social Services Block Grant program and Title III of the Older Americans Act. In some instances, States have included services which may be supported by State supplementary payments to the Federal SSI payment. These services include residential care, foster care, family care, home modifications, non-medical transportation, family placement, housing assistance, nutritional counseling, congregate and home-delivered meals, and emergency alarm response systems. Services otherwise supported by Medicaid, such as nursing services, physical, occupational, and speech therapies have been included in waiver packages, presumably in order that States may expand or restrict the amount, duration, or scope of services for a specified client group.

The client groups most frequently served through the waiver are the aged/disabled and the mentally retarded/developmentally disabled population. Data on waivers approved as of April 30, 1985 show that 50 waivers were targeted to the aged/disabled; 39 waivers to the mentally retarded/developmentally disabled; and 4 to the mentally ill. In addition, as discussed above, under the model waiver program, States have received approval to provide services to limited numbers of blind and disabled individuals, including disabled children with spina bifida, individuals over 21 with multiple sclerosis, children under 3 years of age who are respirator dependent, or persons at risk of a developmental disability (see Table 2-1 and Table 2-2).

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Table 1-1. Section 2176 Home and Community-Based Waiver by
Eligibility Group and Service by State
(Waivers Approved as of April 30, 1985)

	Date Approved	Services Provided by Eligibility Group						
		Case Management	Home- maker	Home Health Aide	Personal Care	Adult Day Care	Habili- tation	Respite Care
Alabama	3/03/83 12/04/84	A/D	A/D		A/D	A/D	MR/DD	A/D
California	11/01/82 6/17/83 10/19/83	A/D	MR/DD	MR/DD A/D		A/D	MR/DD	MR/DD A/D A/D
Colorado	8/17/82 1/06/83 1/06/83	A/D MR/DD	A/D		A/D MR/DD MI	A/D	MR/DD	A/D MR/DD MI
Connecticut	12/10/82	A/D	A/D			A/D		
Delaware	9/27/83	MR/DD					MR/DD	MR/DD
Florida	4/21/82 (expired) 3/06/85 1/ 1/23/85	MR/DD; A/D A/D A/D	A/D A/D A/D		A/D A/D	MR/DD; A/D A/D		MR/DD; A/D A/D A/D
Georgia	6/07/82 (expired) 11/01/84 2/	A/D	A/D	A/D A/D	A/D A/D			A/D
Hawaii	10/28/82 7/15/83 12/31/83	MR/DD A/D A/D	A/D A/D		A/D A/D	MR/DD A/D	MR/DD A/D	MR/DD A/D A/D
Idaho	11/21/84				A/D; MR/DD			
Illinois	6/17/83 9/14/83	A/D MR/DD	A/D			A/D	MR/DD	MR/DD
Indiana	8/28/84	A/D	A/D					A/D
Iowa	5/07/82 (expired)	A/D; MR/DD						
Kansas	3/22/82 (expired) 3/14/85 3/	A/D; MR/DD A/D; MR/DD	A/D; MR/DD A/D; MR/DD	A/D; MR/DD A/D; MR/DD		A/D; MR/DD A/D; MR/DD	A/D; MR/DD A/D; MR/DD	A/D; MR/DD A/D; MR/DD
Kentucky	9/22/82 12/28/83	MR/DD; A/D	MR/DD; A/D	MR/DD; A/D	MR/DD; A/D	MR/DD; A/D A/D	MR/DD	MR/DD; A/D
A-Aged		D-Disabled		MR/DD-Mentally Retarded/Developmentally Disabled			MI-Mentally Ill	

Services Provided by Eligibility Group

[illegible]

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Table 1-1 (continued). Section 2176 Home and Community-Based Waiver by
Eligibility Group and Service by State
(Waivers Approved as of April 30, 1985)

Services Provided by Eligibility Group								
	Date Approved	Case Management	Home- maker	Home Health Aide	Personal Care	Adult Day Care	Habili- tation	Respite Care
Ohio	8/30/84	A/D	A/D	A/D	A/D	A/D		A/D
Oklahoma	11/26/84	HR/DD 6/				HR/DD	HR/DD	HR/DD
Oregon	12/23/81 12/23/81 1/31/85 7/	HR/DD	A/D				HR/DD	HR/DD
Pennsylvania	5/27/83 1/12/84	HR/DD HR/DD				HR/DD HR/DD	HR/DD HR/DD	
Rhode Island	6/30/82 (expired) 1/07/85 8/ 4/25/83 8/23/83	A/D A/D MI HR/DD	A/D A/D HR/DD			A/D A/D MI	HR/DD	HR/DD
South Carolina	8/20/82 12/03/84	A/D A/D			A/D	A/D		A/D
South Dakota	7/06/82	HR/DD					HR/DD	
Tennessee	4/12/84	A/D			A/D			A/D
Texas	4/14/83 4/12/85	A/D MR/DD	HR/DD		A/D		HR/DD	HR/DD
Utah	10/20/82	A/D; HR/DD	A/D; HR/DD	A/D; HR/DD	A/D; HR/DD	A/D; HR/DD	HR/DD	A/D; HR/DD
Vermont	6/23/82 (expired) 3/14/85 9/	HR/DD; MI HR/DD				HR/DD; MI HR/DD	HR/DD; MI HR/DD	HR/DD; MI HR/DD
Virginia	6/18/82				A/D			
Washington	12/17/82 10/26/83	A/D HR/DD			A/D		HR/DD	HR/DD
West Virginia	12/06/82	A/D; HR/DD	A/D	A/D		A/D	HR/DD	A/D; HR/DD
Wisconsin	10/06/83	MR/DD					MR/DD	HR/DD

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Table 1-2. Section 2176 Home and Community-Based Waiver by Eligibility Group and Service by State--Other Services (Waivers Approved of April 30, 1985)

	Date Approved	Client Group	Other Services
California	11/01/82	MR/DD	Adult day training; personal care support; transportation and regional center direct client support services.
	6/17/83	A/D	Housing assistance; in-home supportive services; transportation; meals; protective services; special communications
	10/19/83	A/D	24-hour nursing; adaptations to the home; utility coverage.
Colorado	8/17/82	A/D	Non-medical transportation; adaptations to the home; electrical monitoring/communication device services; alternative care facilities.
	1/06/83	MR/DD	Non-medical transportation, sustaining services.
	1/06/83	MI	Non-medical transportation.
Connecticut	12/10/82	A/D	Occupational therapy; chore; companion; meals on wheels; transportation; mental health counseling.
Delaware	9/17/83	MR/DD	Other clinical support services.
Florida	4/21/82	A/D	Escort; counseling; health support; placement services.
	4/21/82 (expired)	MR/DD	Developmental training; diagnostic and evaluation services; family placement; training; therapy; transportation.
	3/06/85 1/	A/D	Transportation; counseling; escort; health support; placement services.
	1/23/85	A/D	Caregiver health support training; counseling; escort; health support; placement services for adults.
Georgia	6/07/82 (expired)	A/D	Physical, occupational and speech therapy; nursing; special medical supplies, equipment, and appliances; planned therapeutic activities; medical social services.
	11/01/84 2/	A/D	Physical, occupational and speech therapy; nursing; special medical supplies, equipment, and appliances; planned therapeutic services; medical social services; emergency response systems.
Hawaii	12/31/83	A/D	Congregate and home-delivered meals; home maintenance; moving assistance; nutritional counseling; emergency alarm response; environmental modifications; transportation.
Illinois	6/17/83	A/D	Chore/housekeeper; emergency alarm response services.
	9/14/83	MR/DD	Minor home adaptations.
Kansas	3/22/82	A/D;	Adult family homes; congregate care; adult residential services/community living;
		MR/DD	non-medical attendant care; night support; adult failure alarm system; wellness monitoring; hospice care.
	3/14/85 3/	A/D;	Same services as approved in waiver of 3/22/82.
		MR/DD	

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Table 1-2 (continued). Section 2176 Home and Community-Based Waiver by Eligibility Group and Service by State--Other Services (Waivers Approved of April 30, 1985)

	Date Approved	Client Group	Other Services
Kentucky	9/22/82	A/D	Minor home adaptation.
Maine	10/13/83 11/26/84	MR/DD A/D	Transportation. Home health services; transportation; emergency response systems; mental health services.
Maryland	3/04/83	MR/DD	Transportation.
Massachusetts	1/18/83 3/09/84 5/21/84	A/D MR/DD	Personal emergency response services. Chore. Residential care; transportation; adaptive services.
Minnesota	7/23/82 4/17/84	A/D MR/DD	Foster Care. Minor physical adaptations to the home.
Missouri	4/22/82 5/21/84	A/D A/D	Chore. Home health services; chore; medical equipment and supplies; medical transportation; comprehensive pharmacy services.
Montana	2/02/82 5/ 2/03/83	MR/DD A/D; MR/DD	Nursing services; physical, occupational and speech therapy; psychologist services; transportation. Personal care attendant; transportation; emergency alarm response; environmental modifications/rental of adaptive equipment; meals on wheels; congregate meals; physical, occupational and speech therapy; audiology services.
New Hampshire	3/22/84	A/D	Nursing services; personal emergency response systems.
New Jersey	12/28/82 6/08/83	MR/DD A/D	Intervention services. Home health care; medical transportation; pharmaceuticals. 10/
New Mexico	12/22/83	MR/DD	Behavior arrangement; family education and training; specialized non-medical transportation; therapy services.
New York	12/02/82	A/D	Medical social services; nutritional counseling; respiratory therapy; congregate meals; moving assistance; social transportation; housing improvements; home maintenance tasks; emergency alarm response systems.
North Carolina	10/01/82 2/22/83	A/D MR/DD	Chore services; preparation and delivery of meals; skilled nursing; home mobility aids. Home mobility aids; durable medical equipment.
North Dakota	12/07/83	A/D	Non-medical transportation; chore services.
Ohio	8/30/84	A/D	Housekeeper; home-delivered meals; nursing care; physical therapy; non-routine medical supplies; adaptive and assistive equipment.

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Table 1-1 (continued). Section 1076 Home and Community-Based Waiver by
Eligibility Group and Service by State-Consolidated Services
Waivers Approved April 30, 1985

	Date Approved	Client Group	Other Services
Oklahoma	11/26/84	MR/DC	Specialized foster care; early childhood intervention.
Oregon	10/20/83	A/D	Housekeeper chore; non-medical transportation; substitute living; minor home adaptations.
	10/20/83	MC	Residential care facility services.
	12/22/83	MR/DC	Minor home adaptation services.
	1/31/85	A/D	Non-medical transportation; residential care facility services; adult foster care; minor physical home adaptations; in-home services and special needs services.
	1/31/85	MC	Residential care facility services; adult foster care; senior independent living programs.
Pennsylvania	3/27/83	MR/DC	Transportation; physical, occupational, speech, visual, and behavioral therapies; minor home adaptations.
	1/10/84	MR/DC	Transportation; therapy; minor home and adult health centers adaptations.
Rhode Island	6/20/83	A/D	Devices to adapt home environment; minor assistive devices; transportation.
	(expired)		
	1/27/85	A/D	Devices to adapt home environment; minor assistive devices; transportation.
	4/25/83	MC	Transportation.
	5/13/83	MR/DC	Early intervention services; adult foster care; specialized homemaker services; devices to adapt home environment; minor assistive devices; transportation.
South Carolina	12/23/84	A/D	Regular and therapeutic home-delivered meals; physiotherapy, occupational and speech therapy; medical social services.
South Dakota	7/26/83	MR/DC	Dietary services; nursing services; psychological services; physician services; pharmacy and dental; physical, occupational, and speech therapy; audiological and optometric services; eyeglasses; transportation.
Tennessee	4/12/84	A/D	Nursing and therapy services; minor home modifications; durable medical equipment; home-delivered meals; transportation.
Texas	4/14/83	A/D	Emergency response systems; home-delivered meals; minor home modifications; rehabilitation services.
	4/10/83	MR/DC	Nursing services; social services; psychological services; rehabilitation services (OT, PT, speech and audiology).
Utah	10/22/83	A/D; MR/DC	Hospice care; minor home adaptations; night support services; medical alert and monitoring services.
Washington	10/10/83	A/D	Congregate care and licensed adult family home services.
	10/26/83	MR/DC	Nursing; physical, occupational, and behavioral therapy; audiology; dental service medical services, and equipment and supplies.
West Virginia	10/26/83	A/D	Chore; adult family care; personal care; home support services; skilled nursing services.

Footnotes attached

Footnotes for Tables 1-1 and 1-2.

1/ Waiver initially submitted for MR/DD; waiver for mentally retarded was withdrawn on 2/22/85. Replaced waiver of 4/21/82 which expired 3/31/85.

2/ Replaced waiver of 6/7/82 which expired 9/30/84.

3/ Replaced waiver of 3/22/82 which expired 3/21/85.

4/ Terminated by State 8/1/83.

5/ Terminated by State 11/1/83.

6/ Includes regional professional assessment.

7/ Replaced waiver of 12/23/81 which expired.

8/ Replaced waiver of 6/30/82 which expired 12/31/84.

9/ Replaced waiver of 6/23/82 which expired 3/31/85. Waiver initially submitted for mentally ill was withdrawn; waiver request for mentally ill is pending as of 4/85.

10/ Pharmacy services dropped 7/25/84.

Source: Information compiled by CRS from HCFA summary report on 2176 waivers as of April 30, 1985.

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Table 2-1. Section 2176 Model Home and Community-Based Waivers by
Eligibility Group and Service, by State
(Waivers Approved of as of April 30, 1985)

	Date Approved	Case Management	Home- maker	Home Health Aide	Personal Care	Adult Day Care	Habili- tation	Respite Care
Connecticut	3/08/84	MR/DD; D						
Georgia	9/23/83	Disabled children with spinabifida						
	12/11/84	Individuals over 21 with multiple sclerosis						
	12/07/84	Children from birth to 3 years who are respirator dependent						
Idaho	10/11/83	A/D			A/D	A/D		A/D
Iowa	4/17/84		A/D; HR/DD	A/D; HR/DD	A/D; HR/DD	A/D; HR/DD		A/D; HR/DD
Maryland	1/31/85	Disabled children						
Michigan	5/16/83	Disabled children			Disabled children			Disabled children
	1/25/85	HR/DD			HR/DD			HR/DD
Mississippi	3/08/83	Disabled children						
New Jersey	10/04/83	A/D; Disabled children						
New Mexico	3/07/85	Individuals under 21 who are at risk of or have a developmental disability			Individuals under 21 who are at risk of or have a developmental disability			
North Carolina	12/06/83	D; MR/DD children		D; MR/DD children	D; MR/DD children			D; MR/DD children
Ohio	9/21/83 ^{1/}							HR/DD
	12/08/83	MR/DD	HR/DD		HR/DD		HR/DD	HR/DD
	12/29/83	HR/DD	HR/DD		HR/DD		HR/DD	HR/DD
Texas	3/05/85			D; MR/DD under age 21	D; MR/DD under age 21			
A-Aged D-Disabled MR/DD-Mentally Retarded/Developmentally Disabled MI-Mentally Ill								

^{1/} Terminated by State 12/26/83

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Table 2-2. Section 2176 Model Home and Community-Based Waivers by Eligibility Group and Service, by State--Other Services (Waivers Approved as of April 1985)

	Date Approved	Client Group	Other Services
Georgia	12/07/84	Children from birth to 3 years who are respirator dependent	Private duty nursing.
Idaho	10/11/83	A/D	Physical adaptations to the home; attendant care; prescription drugs; non-medical transportation; support services for residential care facilities; prosthetic devices.
Iowa	4/17/84	A/D; MR/DD	Residential care and treatment services.
Maryland	1/31/85	Disabled children	Private duty nursing; home visits by specialty physicians; medical supplies and equipment.
Michigan	5/16/83	Disabled children	Private duty nursing; environmental modification; extended home health; psychological services.
	1/25/85	MR/DD	Psychological services; habilitation skill training; psychological/behavioral treatment services; extended home health; nursing.
New Mexico	3/07/85	Individuals under 21 who are at risk or who have a deve- lopmental disability	In-home nursing; speech, occupational and physical therapy; family training; psychosocial services; environmental modifications.
North Carolina	12/06/83	D; MR/DD children	Nursing; speech, occupational, and physical therapy; durable medical equipment; home mobility aids; child day health.
Ohio	9/21/83 ^{1/}	MR/DD	Air conditioner, cost of installation; pager; transportation.
	12/08/83	MR/DD	Home modification and supplies; transportation.
	12/29/83	MR/DD	Transportation; home modification and supplies.
Texas	3/05/85	D; MR/DD under age 21	Nursing care.

^{1/} Terminated by State 12/26/83.

Source: Information compiled by CRS from HCFA summary report on 2176 waivers as of April 30, 1985.

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Table 3

Number of States, by Service Offered and Eligibility Group
(Waivers Approved as of April 30, 1985) 1/

	Aged/Disabled	Mentally Retarded/ Developmentally Disabled	Mentally Ill
Case Management	31	30	2
Homemaker	26	11	-
Home health aide	11	6	-
Personal care	18	9	1
Adult day care	26	14	2
Habilitation	4	31	1
Respite	24	25	2

Source: Information compiled by CRS from HCFA summary report of 2176
waivers as of April 30, 1985

Table 4

Number of Approved Waivers, by Service Offered
(Waivers Approved as of April 30, 1985) 1/

Case Management	66
Homemaker	39
Home health care	16
Personal care	28
Adult day health	43
Habilitation	36
Respite	52

Source: Information compiled by CRS from HCFA summary report of 2176
waivers as of April 30, 1985

1/ Does not include model waivers

VI. CASE EXAMPLES OF 2176 WAIVERS

In order to provide examples of individual State waiver programs, we selected for review, with HCFA guidance, four State applications which were subsequently approved by HCFA for funding and operation. Summaries of information contained in each of these applications follows. These four applications provide a limited impression of the range and variety of programs by which States have expanded coverage of community-based care.

California's 2176 Waiver Program for Home and Community-Based Care

California's waiver program continues and builds upon a HCFA-sponsored research and demonstration project known as the Multipurpose Senior Services Project. This project, approved in October 1979 and completed in June 1983, provided multidisciplinary case management services, along with other social and health-related services, to frail, low-income elderly persons in order to reduce utilization of nursing home and hospital care as well as expenditures for health and social services.

Purpose of Waiver: To provide a range of home and community based services to aged Medicaid recipients

Services to be Provided: Case management, adult social day care, housing assistance, in-home supportive services, respite care, transportation, meal services, protective services, and special communications

Waiver Period: 3 year period beginning July 1, 1983

Eligibility Group: Aged Medicaid recipients, the majority of whom are categorically needy and a limited number of medically needy

Number of Persons to be Served: 1,900 in year one; 3,400 in year two; and 5,400 in year three

Geographic Area / Number of Sites: In year one, eight different sites throughout the State, with expansion of number of sites in years two and three

Medicaid Requirements For Which Waiver Requested: "Statewide" and "amount, duration, and scope of services" requirements of section 1902(a)(1) and 1902(a)(10)

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Virginia's 2176 Program for Personal Care Services

Virginia's 2176 program has grown out of a pre-admission screening program for nursing home care which has sought to assure appropriate placement of persons in nursing homes. Under its waiver the State provides a single service --personal care.

Purpose of Waiver: To prevent or reduce inappropriate institutional care

Services to be Provided: Personal care services, e.g. assisting with ambulation/exercise, assisting with medication, household services, etc.

Waiver Period: 3 year waiver beginning June 18, 1985; this is a renewal of waiver initially approved June 18, 1982

Eligibility Group: Categorically, optional categorically needy, and medically needy individuals who would otherwise require institutionalization in a SNF or ICF. Income level used for eligibility is 300% of SSI payment standard for one person for the optional categorically needy group

Number of Persons to be Served: 1,690 in FY 1986 (year four); 1,849 in FY 1987 (year five); and 1,978 in FY 1988 (year six)

Geographic Area / Number of Sites: Majority of the State

Medicaid Requirements For Which Waiver Requested: "Statewideness" and "amount, duration, and scope of services" requirements of section 1902(a)(1) and 1902 (a)(10) of the Act

Maine's 2176 Waiver Program for the Mentally-Retarded

Maine's 2176 program has grown out of State efforts to deinstitutionalize mentally retarded persons into less restrictive community settings.

Purpose of Waiver: To provide community-based services to mentally retarded Medicaid eligible recipients

Services to be Provided: Case management, transportation, habilitation, respite care

Waiver Period: 3 year waiver beginning July 1, 1983

Eligibility Group: Eligible mentally retarded Medicaid recipients who would otherwise require institutional care in an ICF/MR; includes persons residing in a Medicaid facility or in the community who, in the absence of the waiver would need or continue to need institutional care in a Medicaid facility. Priority is given to placement of 1) residents of Pineland Center (the State's largest ICF/MR institution) into a less restrictive and less expensive community setting; 2) individuals currently residing in community-based ICF/MR's and eligible for that level of care who could benefit from placement in less restrictive and less expensive community settings; 3) individuals applying for and eligible for ICF/MR level of care who choose services offered under the waiver as an appropriate alternative.

Number of Persons to be Served: 200 in year one; 300 in year two; and 400 in year three

Geographic Area / Number of Sites: Statewide

Medicaid Requirements For Which Waiver Requested: "Amount, duration, and scope of services" requirement of section 1902(a)(10) of the Act

Minnesota's Model Waiver Request

Purpose of Waiver: To provide a range of home and community-based services to chronically disabled children under age 21 who would otherwise require institutional care in a skilled nursing facility which is unavailable, necessitating hospitalization

Services to be Provided: Case management, respite care, environmental modifications to the home, homemaker, family counseling and training, and foster care

Waiver Period: 3 year period effective April 1, 1985

Eligibility Group: Categorically needy, optional categorically needy, and medically needy chronically disabled children under 21

Number of Persons to be Served: 16 in year one; 32 in year two; 50 in year three

Geographic Area / Number of Sites: Statewide

Medicaid Requirements for which waiver is Requested: "Amount, duration, and scope of services" requirements of section 1902(a)(10)

ATTACHMENT A. Section 2176 of P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981; Conference Report language on Section 2176.

97TH CONGRESS
1st Session

HOUSE OF REPRESENTATIVES

REPORT
No. 97-208

NO. 1

OMNIBUS BUDGET RECONCILIATION ACT
OF 1981

CONFERENCE REPORT

[To accompany H.R. 3982]



JULY 29, 1981.—Ordered to be printed

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82-376 O

WASHINGTON: 1981

obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services.

"(c) No waiver under this section may extend over a period of longer than two years unless the State requests continuation of such waiver, and such continuation shall be deemed granted unless the Secretary denies such request in writing within 90 days after the date of its submission to the Secretary.

"(d)(1) The Secretary shall monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a hearing, terminate any such waiver where he finds noncompliance has occurred.

"(2) The Secretary shall report, not later than September 30, 1984, to Congress on waivers granted under this section."

(d)(1) Section 1902(a)(9) of such Act is amended—

- (A) by striking out "and" at the end of subparagraph (A),
- (B) by striking out the semicolon at the end of subparagraph (B) and inserting in lieu thereof ", and", and
- (C) by adding after subparagraph (B) the following new subparagraph:

"(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(2) or paragraphs (11) and (12) of section 1861(s), or, in the case of a laboratory which is in a rural health clinic, of section 1861(aa)(2)(G);"

(2)(A) The amendments made by paragraph (1) shall (except as provided under subparagraph (B)) be effective with respect to payments under title XIX of the Social Security Act for calendar quarters beginning on or after October 1, 1981.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendment made by paragraph (1)(C), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar year beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

WAIVER TO PROVIDE HOME AND COMMUNITY-BASED SERVICES FOR CERTAIN INDIVIDUALS

SEC. 2176. Section 1915 of the Social Security Act (added by section 2175 of this subtitle) is amended—

- (1) by inserting "(other than a waiver under subsection (c))" in subsection (c) after "No waiver", and

(2) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

"(c)(1) The Secretary may by waiver provide that a State plan approved under this part may include as 'medical assistance' under such plan home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan.

"(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

"(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

"(B) the State will provide, with respect to individuals who are entitled to medical assistance for skilled nursing facility or intermediate care facility services under the State plan and who may require such services, for an evaluation of the need for such services;

"(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of skilled nursing facility or intermediate care facility services;

"(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

"(E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

"(3) A waiver granted under this subsection may include a waiver of the requirements of subsection (a)(1) (relating to statewideness) and subsection (a)(10). A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional three-year periods unless the Secretary determines that for the previous three-year period the assurances provided under paragraph (2) have not been met.

"(4) A waiver granted under this section may, consistent with paragraph (2)—

"(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of

medical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

"(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, home-maker/home health aide services and personal care services, adult day health, habilitation services, respite care, and for such other services requested by the State as the Secretary may approve."

TIME LIMITATION FOR ACTION ON REQUESTS FOR PLAN AMENDMENTS AND WAIVERS

SEC. 2177. (a) Section 1915 of the Social Security Act, (added by section 2175 of this subtitle) is further amended by adding at the end thereof the following new subsection:

"(f) A request to the Secretary from a State for a proposed State plan or plan amendment or a waiver of a requirement of this title submitted by the State pursuant to a provision of this title shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request."

(b) The amendment made by this section shall become effective 90 days after the date of the enactment of this Act.

FLEXIBILITY IN PREPAID PROVIDER (HMO) PARTICIPATION IN STATE PLANS

SEC. 2178. (a)(1) Paragraph (1)(A) of section 1903(m) of the Social Security Act is amended by striking out "means" and all that follows through the end thereof and inserting in lieu thereof the following: "means a public or private organization, organized under the laws of any State, which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) or which—

"(i) makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and

"(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization's insolvency."

(2) Paragraph (2)(A) of section 1903(m) of such Act is amended—

(A) by striking out "and" at the end of clause (i),

97TH CONGRESS
1st Session

} HOUSE OF REPRESENTATIVES

{ REPORT
No. 97-208

NO. 2

OMNIBUS BUDGET RECONCILIATION ACT
OF 1981

CONFERENCE REPORT

[To accompany H.R. 3982]



JULY 29, 1981.—Ordered to be printed

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6. *Elimination of EPSDT penalty*

House bill.—The House bill repeals the current law provision which subjects States to a 1 percent reduction in Federal matching payments under their Aid to Families with Dependent Children program (AFDC) if they fail to meet certain performance standards for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services under Medicaid. The House bill further incorporates the EPSDT standards under title XIX.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision. It is the intention of the conference committee that States should continue to develop fully effective EPSDT programs. However, the current EPSDT reporting requirements, which entail a large volume of paperwork, should be significantly streamlined.

7. *Repeal of required medicaid coverage for individuals aged 18-20*

A. House bill.—The House bill repeals the requirement that States provide Medicaid coverage to persons under 21 who would be eligible for AFDC if attending school and instead makes coverage of such individuals optional.

Senate amendment.—Similar provision.

Conference agreement.—The conference agreement includes the Senate provision.

B. House bill.—No provision.

Senate amendment.—The Senate amendment allows States which choose to cover children under Medicaid who would be eligible for AFDC except for a school attendance requirement to limit such coverage to children under 21, 20, 19, or 18, or any reasonable category of such children.

Conference agreement.—The conference agreement includes the Senate amendment.

8. *Removal of medicare reasonable charge limitation*

House bill.—The House bill repeals the requirements that State Medicaid payments for physicians' services and certain medical supplies and laboratory services cannot exceed reasonable charge levels established under Medicare.

Senate amendment.—The Senate amendment modifies the House bill to provide that the existing Medicare limit must be applied in the aggregate.

Conference agreement.—The conference agreement includes the House provision.

* 9. *Options for the provision of home and community-based care and requirement of preadmission screening for long-term care patients*

A. House bill.—The House bill authorizes States, subject to approval by the Secretary, to provide Medicaid coverage for a range of home and community-based services pursuant to an individual plan of care to persons determined through a comprehensive assessment, to be in need of long-term skilled nursing facility (SNF) or intermediate care facility (ICF) services.

Senate amendment.—The Senate amendment authorizes the Secretary to waive Federal requirements to enable a State to cover

personal care services and other services pursuant to an individual plan of care to persons who would otherwise require institutionalization.

Conference Agreement.—The conference agreement includes the Senate provision with the following modifications: (1) States must determine that individuals would otherwise need institutional care. Currently, certification by a physician is often all that is required for nursing home placement. The conferees recognize that many medical and non-medical factors bear on a decision to seek long-term care, and thus all factors relating to the need for institutionalization should be taken into account in the evaluation of such need.

(2) States must determine that it is reasonable to provide individuals with alternative services, available at their choice, pursuant to a plan of care. While it is expected that the existence of alternatives will encourage the acceptance of community care, the conferees emphasize that the integrity of patient choice should be preserved. The determination of which long-term care options are feasible in a particular instance should be based on the individual's needs, as determined by an evaluation, and not short-term cost savings. While the conferees anticipate that the provision of community-based care will have a long range and significant impact on the size of States' Medicaid budgets, they do not believe that States should make decisions regarding the feasibility of community-based care on the basis of whether or not such arrangements will produce short-term cost savings. 3) The State must provide for the formulation of a written plan of care for persons provided waived services, and must determine that the making available of alternative services to such persons would not result in overall expenditures in excess of those which would be incurred if that person were institutionalized. The cost of physician visits, hospitalization, prescription drugs, etc. that the individual would have received would be included in the State's estimates of Medicaid expenditures in addition to the cost of SNF or ICF care for that individual. 4) The following services may be included in the State program: nursing, medical supplies and equipment, physical and occupational therapy, and speech pathology and audiology, now authorized. Additional services which may be included are homemaker/home health aide personal care services; adult day health; habilitation; case management; respite care; and other services requested by the State and approved by the Secretary. Homemaker and adult day health care are defined in Title XX of the Social Security Act. Habilitation encompasses both health and social services needed to insure optimal functioning of the mentally retarded and the developmentally disabled. Respite care services are given to an individual unable to care for him/herself and which are provided on a short-term basis to such an individual because of the absence or need for relief for those persons normally providing such care. Services can be offered in the home of an individual or in an approved facility such as a hospital, nursing home, foster home, or community residential facility. Case management is a system under which responsibility for locating, coordinating and monitoring a group of services rests with a defined person or institution. 5) The State may set limitations on the amount, duration and scope of services provided to individuals pursuant to the waiver which may vary from that made available

to other Medicaid recipients. The Conferees recognize that in order to provide an appropriate mix of services tailored to the individual, it might be inadvisable to set definitive limits on each service, since the written plan of care delineates the number and frequency of services, and the State may establish a per capita ceiling on the total cost of each client's care.

B. House bill.—The House bill provides that the Secretary may not approve such coverage unless the State provides assurances that implementation would not result in a level of expenditures for all long-term services greater than the level of expenditures without coverage for such noninstitutional services.

Senate amendment.—No provision.

Conference Agreement.—The conference agreement follows the House provision with a modification to specify that the total of all medical assistance for services provided to individuals who would qualify for community-based care under the State program may not exceed, on an average per capita basis, the total expenditures which would be incurred for such individuals if they were institutionalized. In determining the per capita costs the conferees expect the costs of medical assistance for these community-based care recipients will be divided by the number of individuals who are determined likely to be institutionalized without these services. The conferees believe this will provide protections to assure that aggregate costs will not be greater than they would have been without these alternative services.

C. House bill.—The House bill would permit the Secretary to approve coverage for room and board services.

Senate amendment.—The Senate amendment would not authorize coverage for such services.

Conference agreement.—The conference agreement does not include the House provision.

D. House bill.—No provision.

Senate amendment.—The Senate amendment authorizes the Secretary to grant a waiver only if State assures that necessary safeguard have been taken to protect the health and welfare of any recipients of such services.

Conference agreement.—The conference agreement follows the Senate amendment with an additional amendment requiring States to provide assurances that they will maintain appropriate financial records documenting the cost of services provided pursuant to the waiver; such records must be made available on request to the Secretary.

E. House bill.—The House bill provides that effective October 1, 1982, Federal matching payments would not be available for SNF or ICF services provided to individuals who had not received a comprehensive assessment of their need for long-term institutional care prior to admission to an SNF or ICF, except in urgent circumstances as provided by the Secretary.

Senate bill.—No provision.

Conference agreement.—The conference agreement does not include the House provision. However, the conferees note that if a State has an assessment system for persons needing long-term care, the costs of that system are eligible for Federal matching under the current Medicaid program.

F. House bill.—The House bill provides that a waiver granted a State under this provision shall be for three years, and may include a one-time waiver of Statewideness. Upon the request of the State, the waiver shall be extended for additional three-year periods unless the Secretary determines the assurances provided by the State have not been met.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House provision.

The conferees note that the Department of Health and Human Services has supported demonstrations in 13 States, chiefly through waiver authority, to allow Medicare and Medicaid funds to pay for a variety of home and community-based services under different systems of organization and reimbursement. While these programs on the whole have States have received little encouragement to make permanent changes in long-term care provision, and many of these projects will terminate in the near future. The Conferees feel these projects will provide data useful to States requesting waivers under this section. Therefore, they direct the Secretary of HHS to review the progress of these demonstrations, and to consider continuing funding for those projects which are meeting their stated goals.

10. Encouraging HMO Participation in State Medicaid Plans

A. House bill.—The House bill maintains the current law requirement that States enter into prepaid risk arrangements only with federally qualified HMO's. It requires that States entering into agreements with HMO's do so under a contract containing financial accountability, nondiscrimination, and voluntary disenrollment provisions.

Senate amendment.—The Senate amendment repeals the current law provision that requires States that choose to enter into prepaid capitation or other risk-based arrangements to do so only with entities that meet Federal HMO standards (under title XIII of the Public Health Service Act), with certain exceptions. The Senate amendment permits a State to make payment on a prepaid capitation or other risk basis to any providers of services.

Conference agreement.—The conference agreement follows the House provision with an amendment to permit States to enter prepaid arrangements with other entities provided that such entity: (a) make covered services to Medicaid enrollees accessible on the same basis as to other Medicaid eligibles in the area; (b) has made adequate provision against risk of insolvency. Individuals eligible for benefits under a prepaid arrangement would in no case be held liable for debts of the organization in case of the organization's insolvency.

B. House bill.—The House bill modifies the current requirement that provided that within three years of entering into a Medicaid contract with a State an HMO must have an enrollment that consists of less than 50 percent Medicaid and Medicare beneficiaries. The House bill raises the current ceiling on Medicaid and Medicare beneficiaries in HMO's to 75 percent of enrollment and authorizes the Secretary to waive this ceiling altogether for public HMO's.

Senate amendment.—The Senate amendment repeals the current ceiling.

ATTACHMENT B. Department of Health and Human Services Interim and Final Regulations on the Section 2176 Waiver Program.

final regulations

Thursday
October 1, 1981

Part V

Department of Health and Human Services

Health Care Financing Administration

Medicaid Program; Home and
Community-Based Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration 42 CFR Parts 431, 435, 440, 441

Medicaid Program; Home and Community-Based Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This rule amends current Medicaid regulations to permit States to offer, under a Secretarial waiver, a wide array of home and community-based services that an individual may need in order to avoid institutionalization. Before enactment on August 13, 1981, of the Omnibus Budget Reconciliation Act of 1981, little coverage under Medicaid was available for noninstitutional long-term care services. Conversely, institutional long-term care services represent a significant part of the budgets of State Medicaid programs.

These regulations, which implement section 2176 of Pub. L. 97-35, allow Federal payment for these noninstitutional services, subject to HCFA's approval of the States' request for waivers and to certain assurances made by the States. Once granted, waivers are in effect for 3 years and are renewable. On an annual basis, the States must report to HCFA on the impact and effectiveness of the program.

EFFECTIVE DATES: October 1, 1981. These regulations are being published in final, for reasons described in the Supplementary Information, below. However, we will consider any written comments mailed by December 30, 1981 and will revise the regulations if necessary.

Sections 441.300-441.305 of these regulations contain reporting requirements subject to the Paperwork Reduction Act (Pub. L. 96-511) that have not been approved by the Office of Management and Budget. The reporting is not required until the Office of Management and Budget approval has been obtained. HCFA will publish a notice in the Federal Register when approval has been obtained, indicating the effective date of the reporting.

ADDRESS: Address comments in writing to: Administrator, Department of Health and Human Services, Health Care Financing Administration, P.O. Box 17076, Baltimore, Maryland 21235.

If you prefer, you may deliver your comments to Room 309-C Hubert H. Humphrey Building, 200 Independence Ave., S.W., Washington, D.C., or to Room 789, East High Rise Building, 6325

Security Boulevard, Baltimore, Maryland.

In commenting, please refer to EPP-182-FC. Agencies and organizations are requested to submit comments in duplicate.

Comments will be available for public inspection, beginning approximately two weeks after publication, in Room 309-G of the Department's office at 200 Independence Ave., S.W., Washington, D.C. 20201 on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (202-245-7890).

Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, if as a result of comments, we believe that changes are needed in these regulations, we will publish the changes in the Federal Register and respond to the comments in the preamble of that document.

FOR FURTHER INFORMATION, CONTACT: Robert Wren, (301) 594-9820.

SUPPLEMENTARY INFORMATION:

Background

Until Pub. L. 97-35, the Omnibus Budget Reconciliation Act, was signed on August 13, 1981, the Medicaid program provided little coverage for long-term care services in a noninstitutional setting, but offered full or partial coverage for such care in an institution. Even though only approximately 6 percent of the elderly reside in an institution, more than 40 percent of Medicaid expenditures was for long-term institutional care in the most recent year for which data are available.

The House Report accompanying the House Omnibus Reconciliation Bill (H. Rept. 97-158, p. 316) notes that it has been estimated that a quarter of the current nursing home population do not need full-time, residential care. Many elderly, disabled and chronically ill persons live in institutions not for medical reasons, but because of the paucity of health and social services available to them in their homes or communities, and the individual's inability to pay for those services or to have them covered by Medicaid when they do exist.

Assessment procedures required under Medicaid to determine the need for institutional care for the elderly and disabled have not been adequate in preventing avoidable admissions. Most of the reviews occur after admission to the long-term care facility, when it is most difficult to discharge the resident back to the community. In addition, the reviews focus on medical conditions, primarily, and not on social and other

factors that are often more critical in determining the most suitable placement.

Statutory Amendments

Section 2176 of Pub. L. 97-35 added new provisions to the Social Security Act to deal with the circumstances described above, by inserting a new subsection 1915(c). (Section 1915 itself was added by section 2175 of Pub. L. 97-35.) The subsection authorizes the Secretary of HHS to waive Medicaid statutory limitations in order to enable a State to cover a broad array of home and community-based services. All such services must be furnished under an individual written plan of care, and may only be furnished to persons who would otherwise require the level of care provided in a skilled nursing facility (SNF) or intermediate care facility (ICF) for which the cost could be reimbursed under the State plan. The law provides that the Secretary will not approve the State's request for a waiver unless the State provides satisfactory assurances to the Secretary that:

1. Necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of beneficiaries provided services under the waiver and to assure financial accountability for funds spent for the services;
2. The State will provide for an evaluation of the need for the inpatient services for individuals who are entitled to and who may require the level of care provided in an SNF or ICF under the State plan;
3. Any individuals who are determined to be likely to require the level of care provided in a SNF or ICF are informed of the feasible alternatives available under the waiver, and are given the choice of the inpatient services or the alternative noninstitutional services;
4. The average per capita expenditure estimated by the State in any fiscal year for medical assistance provided to these individuals does not exceed the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for these individuals if the waiver had not been granted; and
5. The State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver on the type and amount of medical assistance provided under the State plan and on the health and welfare of its beneficiaries.

Additionally, the law specifically provides that a waiver granted under section 1915(c) may include a waiver of the requirements of section 1902(a)(1) and (10) of the Social Security Act. Under section 1902(a)(1) of the Act, a State plan for medical assistance must be in effect throughout the State. Section 1902(a)(10), as amended by Pub. L. 97-35 of the Act, sets forth certain Medicaid eligibility and service coverage requirements. It requires the plan to provide that services available to the categorically needy beneficiary are not less in amount, duration and scope than services available to the medically needy and are equal in amount, duration and scope for all categorically needy beneficiaries.

Waivers granted under section 1915(c) of the Act shall be for an initial term of three-years and, if requested by the State, shall be extended for additional three-year periods unless the Secretary determines that, for the previous three-year period, the State did not meet the assurances discussed above (in (1) through (5)).

Section 1915(d), as added by section 2175 and redesignated as section 1915(e) by section 2176 of Pub. L. 97-35, provides that the Secretary shall monitor the implementation of the waivers granted to determine if the requirements of the waivers are being met. After giving the State notice and an opportunity for a hearing, the Secretary shall terminate any waivers if noncompliance has occurred.

Under the waiver, the State may exclude those individuals for whom there is a reasonable expectation that home and community-based services would be more expensive than Medicaid services the individual would otherwise receive.

A waiver will allow a State to provide Medicaid to individuals for such services as case management, homemaker, home health aide, personal care, adult day health, habilitation, and respite care, and other services requested by the State and approved by the Secretary. The services must be consistent with plans of care, which are subject to the State's approval.

Section 2177 of the Omnibus Budget Reconciliation Act of 1981 also amends the new section 1915 of the Social Security Act. It adds a new subsection (f) that affects subsection (c) as well as other parts of title XIX. Section 1915(f) provides that a request from a State for approval of a State plan amendment or waiver, including a waiver request under section 1915(c), shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies the request

in writing or informs the State in writing of any additional information needed to make the determination on the request. The request will be deemed granted 90 days after the receipt of the additional information, unless the Secretary denies the request in writing within the 90 days.

Regulatory Provisions

The provisions of the new regulations parallel the statute with clarifying or implementing policy as discussed below.

The new regulations add a new § 440.180, defining home or community-based services, to 42 CFR Part 440; and a new Subpart G to Part 441, specifying requirements for providing these services. They also add new §§ 435.222, 435.726, and 435.735 to the eligibility regulations, specifying new eligibility provisions that allow States to cover certain individuals who would otherwise be institutionalized. The regulations also make technical amendments to § 431.50, Statewide needs; § 440.1, the basis and purpose section of the regulations defining Medicaid services; § 440.170(f), Personal care services in a recipient's home; and § 440.250, Limits on comparability of services.

The purpose of these regulations is to give the States the maximum opportunity for innovation in furnishing noninstitutional services to beneficiaries, with a minimum of Federal regulation. Basically, we will measure the States' proposals against the statutory requirements rather than against a detailed additional set of Federal guidelines or criteria. That is, we will require the State requesting a waiver to describe its proposal, to explain how it satisfies the statutory requirements of section 1915(c) and, with regard to some specific requirements, to make assurances that those requirements are met. However, we are not generally mandating how the States must establish or implement their community care programs.

Using our experience with demonstration projects, which tested an expanded range of noninstitutional services, we will be able to offer technical assistance to States interested in requesting waivers. We can provide the States with information, for example, on successful procedures and services for a case management system and home health aides. We can also provide assistance to States that they can use in developing their community care programs and, in requesting appropriate waivers and State plan changes.

Note.—References in this document to "the level of care provided in an ICF" include the level of care provided to beneficiaries in

ICFs for the mentally retarded (ICF/MR) (42 CFR 440.150(c)).

A. Definition of Services

The regulations provide that home or community-based services for which a waiver may be granted under this provision may consist of the following services (other than room and board):

1. Case management services.
2. Homemaker services.
3. Home health aide services.
4. Personal care services.
5. Adult day health services.
6. Habilitation services.
7. Respite care services.

8. Other services requested by the State and approved by the Secretary.

We are not going to try to define these terms in our regulation. Instead, we are requiring that the States define them in their waiver request. The States thus have broad discretion in determining the nature of the services to be covered, subject to the budgetary restraints discussed below.

The following discussion of services is presented solely for the purpose of providing the States with suggestions on how they might begin developing a waiver proposal.

1. "Case management" is commonly understood to be a system under which responsibility for locating, coordinating and monitoring a group of services rests with a designated person or organization. It was Congress' view (H. Rept. 97-158, p. 321) that the case manager should be responsible for locating available sources of help from within the family and community so that the burden of care will not be exclusively borne by formal health and social agencies. Thus, an "informal network" of friends, relatives, churches, etc., can be used wherever feasible to strengthen the elderly or disabled person's ties with his or her own community.

2. "Homemaker services" is normally viewed as consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself or others in the home.

3. "Home health aide services" would typically include the performance of simple procedures such as the extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing

appropriate records. (See 42 CFR 405.1227(a) and 440.70 for the Medicare and current Medicaid provisions on home health aides.)

4. "Personal care services" are presently defined for the Medicaid program in 42 CFR 440.170(f) as services furnished to a recipient in his or her home that are prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is—

- (i) Qualified;
- (ii) Supervised by a registered nurse; and
- (iii) Not a member of the recipient's family.

States can furnish home health aide and personal care services under their State plan without seeking a waiver under section 1915(c). However, they can also seek such a waiver to provide these services in a manner that departs from these definitions.

5. "Adult day health services" are discussed in the legislative history as encompassing "both health and social services needed to insure the optimal functioning of the client, as well as habilitation services suitable for the care of the mentally retarded and the developmentally disabled" (H. Rept. 97-158, p. 321). In our view, such care should be furnished for four or more hours per day on a regularly scheduled basis, for one or more days a week in an outpatient setting. We also believe that meals provided as a part of these services could be covered. Although section 1915(c)(1) has a general prohibition against the payment for room and board, the Conference Report (H. Rept. 97-208, p. 966) indicates that Congress was aware of the manner in which homemaker and adult day health services are provided under title XX. That statute contains a similar prohibition against payment for "room and board". The title XX regulations at 45 CFR 1396.1 define "board" as "three meals a day or any other full nutritional regimen". Under this definition, title XX now pays for individual meals provided as part of adult day health services. We are adopting the title XX approach. Accordingly, Federal financial participation (FFP) will be available for meals that are provided as a part of adult day health services.

6. "Habilitation services" are typically health and social services needed to insure optimal functioning of the mentally retarded or persons with related conditions.

7. "Respite care"—The Conference Report (H. Rept. 97-208, p. 966) states that respite care is given to individuals unable to care for themselves and is provided on a short term basis to the

individual because of the absence or need for relief of those persons normally providing the care. Respite care services may be provided in the individual's home or in a facility approved by the State such as a hospital, nursing home, foster home or community residential facility. As noted above, section 1915(c)(1) of the Act precludes Federal payment for room and board when furnished as a home or community-based service. However, since the statute specifically authorizes the provision of respite care, and the Conference Report indicates that Congress intended that respite care include full-time, short-term institutional care, which always under the Medicaid program has included room and board, we have concluded that Congress intends to create an exception to the general statutory prohibition against room and board. Accordingly, Federal funds will be available for respite care provided under the waiver, including any room and board that may result from furnishing respite care outside a private residence. When respite care is furnished in a setting that charges a "per diem" rate, the room and board is considered part of the "per diem" rate.

8. Other services—The State may also request HCFA's approval to provide other home and community-based services not listed here. Such services may include, for example, but not be limited to, nursing care, medical equipment and supplies, physical and occupational therapy, speech pathology and audiology, and minor physical adaptations to the home. We will approve these services and others if the State demonstrates in its waiver request that they are cost-effective (i.e., their cost would not raise the cost of home and community-based care for the beneficiaries to whom they are provided to an amount greater than the cost of the level of care provided in an SNF or ICF), describes the services in detail, and assures HCFA that the services are necessary to avoid institutionalization.

B. Content of Waiver Requests

Requests for waivers must contain—

- (1) The information as described below in C;
- (2) The assurances discussed below in D; and
- (3) The required supporting information discussed below in E.

Section 1915(c) describes this provision as a waiver. We are implementing it in that fashion. Therefore, we are requiring that the State submit supporting explanation and documentation in the form of a waiver request. If the State does not intend to offer home and community-based

services to all individuals who would otherwise likely require institutionalization, it must also include a request for a waiver of the requirements of either section 1902(a) (1) or (10) of the Social Security Act, or both, if applicable. If the State intends not to offer the home or community-based services to beneficiaries on the basis that it can reasonably expect that the services would cost more than the services the beneficiaries would otherwise receive, the State must also explain in its waiver request how it will make and implement such determinations.

C. Waiver Request Requirements

The waiver request must describe the services the State is offering under the waiver and who is eligible to receive them. It must also state that the services will only be furnished to those eligible beneficiaries who, but for the provision of the home and community-based services, would require the level of care provided in an ICF or SNF.

The request must indicate how the statutory requirements for a plan of care will be met. The services provided a beneficiary must be furnished under a plan of care that is written specifically for that beneficiary. The State has discretion in designing the plan of care process and prescribing who writes individual plans of care. Based on our experience and that of the States, we expect the plan of care to include the medical and other services to be given, their frequency, and the type of provider to furnish them. Plans of care are subject to the State's approval, and the State has the discretion to set up its own approval process. The waiver request must include a description of the qualifications of the individual or individuals who will be responsible for developing the individual plan of care.

D. State Assurances

Section 1915(c) of the Act explicitly requires that a waiver can be approved only if the State provides us with satisfactory assurances of the following:

- 1. *Safeguards*—The State must assure us that necessary safeguards have been taken to protect the health and welfare of the beneficiaries receiving the services. Under the statute, these safeguards must include adequate standards for provider participation. These regulations do not attempt to define these safeguards or to prescribe how they are to be developed. It is the State's responsibility to determine what the necessary safeguards are, to define them or specify how they will be developed and implemented, and to

explain how they satisfy the statute. If the State has licensure or certification requirements for any services (or for the individuals who furnish these services) provided under the waiver, it must assure HCFA that the standards in the licensure or certification requirements will be met.

The State must also assure us that it will maintain, and require providers of these services to maintain, financial accountability for funds expended with respect to these services. Again, it is the State's responsibility to inform us how it will meet this requirement and, in particular how it will assure that there is an audit trail for all State and Federal funds.

2. Individual assessments.—Services under the waiver may be furnished only to an individual who, but for these services, would require the level of care provided in an SNF or ICF. This does not mean that the individual must be receiving the level of care provided in an SNF or ICF before receiving the noninstitutional services. It means, rather, that the individual, in the absence of the noninstitutional services, would require the level of care provided in an SNF or ICF. Thus, the state must assure us that, for each beneficiary encompassed by the waiver, it will provide an objective method for evaluating the beneficiary's need for the level of care provided in an SNF or ICF.

The new section requires the States to provide for an evaluation of the need for the level of care provided in an SNF or ICF with respect to all individuals who are entitled to medical assistance for these services and who may require these services. Section 1903(g) of the Act requires specific recertification of the need for institutional care with respect to beneficiaries who are already inpatients. Accordingly, under the waiver, a State would not be required to perform any further evaluation of those inpatients, although it would, of course be free to do so. It would, however, be required to perform an evaluation for all beneficiaries or Medicaid applicants for whom there is a reasonable indication that they might need the level of care provided in an SNF or ICF in the near future. In making this evaluation, the level of care provided in an SNF or ICF, as defined at 42 CFR 440.40 and 440.150 respectively, must be used. Other factors, whether medical or not, may be employed as the State deems appropriate. The State, in its assurance, must include a copy of the written assessment instrument that will be used, must describe how those assessments will be made, and specify who has responsibility for doing them.

The waiver request would have to describe, for example, the party or parties responsible for the assessment, what factors they will use to evaluate and reevaluate the recipient's need for the level of care provided in an SNF or ICF, and when evaluations and reevaluations will be made.

Our regulations require that the State maintain written documentation of all such evaluations and reevaluations. (The State need not keep the documentation itself but may arrange for the provider or for another person or agency to keep it.) The State must include in its waiver request an explanation of how it will satisfy this requirement. Congress clearly intended that these services would be made available only to individuals who had been determined to need inpatient SNF or ICF services in the absence of the alternative noninstitutional services. Therefore, we believe the maintenance of documentation is necessary to insure an audit trail and to enable us to determine whether only those individuals who would otherwise have required institutionalization were being provided these services.

3. Informing beneficiaries of choice.—Beneficiaries determined to be likely to require an SNF or ICF level of care must be informed of the feasible alternatives and given a choice as to which type of services to receive. (This would not apply to beneficiaries for whom there is a reasonable expectation that the cost of home and community-based services would be more than the cost of SNF or ICF care, if the State indicates in its waiver request that it will exclude these individuals from coverage under the waiver. See discussion in B above.) The State must explain in its waiver request how this requirement will be met and assure us that it will be met. We are not, however, requiring that the State document that each beneficiary (or his or her representative) has been so informed. In the absence of information to the contrary, we will accept the State's assurance that it has been done.

The Congressional Conference Committee, in its report on this amendment (H. Rept. 97-208, p. 966) emphasized that, while it is expected that the existence of alternatives will encourage the acceptance of community care, the integrity of patient choice must be preserved. The determination of which long-term care options are feasible in a particular case should be based on the individual's needs, as determined by an evaluation, and not on short-term cost savings.

As with other services under Medicaid, a beneficiary who is not given the choice of home or community-based

services as an alternative to SNF or ICF services may request a fair hearing under 42 CFR Part 431, Subpart E, unless the reason for the denial is that the group of which the individual is a part is not included within the scope of the waiver (see 42 CFR 431.220(b)). Since a finding that home or community-based services are not feasible in a particular case constitutes a denial of services covered under a State's Medicaid plan, the Medicaid statute (section 1902(a)(3)) requires that applicants and beneficiaries be provided the procedural protections of the Medicaid administrative hearing process as described in 42 CFR Part 431, Subpart E.

4. Average per capita expenditures.—Congress was concerned that the total of all medical assistance for services provided to individuals who would qualify for home or community-based care under the State plan not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available. Accordingly, the statute and these regulations provide that the State, in its waiver request, must assure us that the average per capita expenditure under the waiver does not exceed the average per capita expenditure, as reasonably estimated by the State, that would have been made under the State plan had the waiver not been granted. Congress expected that this provision would assure that aggregate costs will not be greater than they would have been without these alternative services. (H. Rept. 97-208, p. 967)

Average per capita expenditures for services for this purpose means the aggregate Medicaid payment for all long-term care services furnished (taking into account the utilization of each type of service) divided by the number of beneficiaries expected to receive services. (We are excluding from these calculations services other than long-term care services, since they should be unaffected by the waiver, and their inclusion would simply make the calculations more burdensome.) These estimates must cover each fiscal year during the 3-year term of the waiver. To be granted approval by HCFA, the estimates must be reasonable, based on statistically sound and valid procedures, and verifiable. To develop the required assurances, the State will have to develop estimates of the costs and utilization for each type of service and an estimate of the total population that would likely receive these services.

The estimated average per capita expenditures under the waiver is obtained by multiplying (A) the

estimated number of beneficiaries who would receive the level of care provided in an SNF or ICF under the waiver times (B) the estimated Medicaid payment per eligible Medicaid user of such care; and adding that figure to the product of (C) the estimated number of beneficiaries who would receive home and community-based services under the waiver or other noninstitutional alternative services included under the State plan times (D) the estimated Medicaid payment per eligible Medicaid user of such services. This figure is to be divided by (F) the estimated number of beneficiaries who would receive the level of care provided in an SNF or ICF under Medicaid in the absence of the waiver plus (H) the estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.

To illustrate,

$$\frac{A \times B + C \times D}{F + H} = \text{the estimated average per capita expenditure under the waiver.}$$

per capita expenditure under the waiver.

Note.—The product of $A \times B$ would be calculated separately for SNF and ICF levels of care and then added. Similarly, the product of $C \times D$ would be calculated for each type of service covered under the waiver and then added. Thus, the numerator would be the sum of all these products—or the estimated aggregate cost for all long-term care services offered under the plan.

Next, the State will develop an estimate of average per capita expenditures that would result in the absence of a waiver. This estimate is obtained by multiplying (F) the estimated number of beneficiaries who would receive the level of care provided in an SNF or ICF in the absence of the waiver times (G) the estimated Medicaid payment per eligible Medicaid user of such care; and adding that figure to the product of (H) the estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care times (I) the estimated Medicaid payment per eligible Medicaid user of such noninstitutional services. This figure will be divided by the same denominator as before—namely, (F) the estimated number of beneficiaries who would receive the level of care provided in an SNF or ICF under Medicaid in the absence of the waiver plus (H) the estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.

To illustrate,

$$\frac{F \times G + H \times I}{F + H} = \text{the estimated average per capita expenditures in the absence of a waiver.}$$

In both of these computations the denominator (i.e., the estimated number of beneficiaries who would likely receive the level of care provided in an ICF or SNF under Medicaid in the absence of the waiver) must be the same number for like periods of time. In particular, if the State wishes to revise its estimate of the denominator at some point after a waiver is approved (in order to adjust for an error in the estimate or for adding an unanticipated increase in the eligible population), that revision would be made in both calculations and the comparison would be re-examined to determine if the waiver is still cost effective.

In developing the estimates of utilization necessary to complete the above computations, the State must use actual data on nursing home cost and utilization and on cost and utilization of community-based services for the most recent year before the waiver takes effect. These figures would be adjusted by the State to reflect anticipated growth in the supply of nursing home beds, availability of community-based services and inflation. Similarly, the State's experience with utilization and cost of home and community-based services provided under title XIX, title XX and other programs should provide a useful basis for the necessary estimates.

The State, in its waiver request, must inform HCFA of what its per capita expenditures are, describe how these were estimated, and describe the factors it employed in deriving the estimates. HCFA will review these estimates very closely to determine if they are reasonable and based on statistically supportable assumptions. Further, HCFA will compare these estimates with data the State must furnish annually on its actual experience. In the event of a discrepancy between actual and estimated per capita expenditures, HCFA will ask the State to explain the basis for the difference or to adjust its estimates.

We will provide further guidance on how to develop estimating methodology and will provide technical assistance to States that request it.

5. Annual report on impact.—The State must assure us that it will provide us annually with information on the impact of the waiver on the type and amount of services provided under the State plan and on the health and welfare of the beneficiaries. The data will have to be consistent with a data collection plan

we are designing. We will provide further guidance to the States on what data must be submitted and in what form. However, such data would include, but not be limited to, the State's actual per capita expenditures for services provided under the waiver.

D. Duration of Waiver

If we approve a waiver request, the waiver may continue for three years. The waiver may be extended for three-year periods thereafter if the State requests it, unless our review of the prior three-year period shows that the assurances the State offered were not met.

The development and implementation of a State home and community-based services program is a time-consuming and complex process, often requiring the coordination of several agencies and, sometimes, State legislative action. In recognition of this, Congress provided that the waiver would be for three-year periods of time. However, Congress also provided in the amendments for the Secretary to monitor implementation of the waivers to assure that the requirements for them are being met. Thus, if HCFA finds that a given State is not meeting the assurances it made in its waiver request or any of the other requirements for a waiver specified in this subpart, the State will be given a notice of these findings and an opportunity for a hearing to rebut the findings. If, after the proceedings, HCFA determines that the State is not in compliance, HCFA will terminate the waiver. Possible grounds for termination will include excessive costs.

If a State wants to terminate its waiver before the completion of the three-year period and no longer provide home and community-based services, it must submit a written request to HCFA showing its intent to terminate the waiver 30 days before terminating services.

Whether HCFA or the State terminates the waiver, the State must notify beneficiaries receiving services under the waiver in accordance with 42 CFR 431.210 and must notify them 30 days before ending services. The State does not have to offer a hearing to beneficiaries when a waiver is terminated.

E. HCFA's Review of Waiver Requests

When we receive a request for a waiver, we will review its contents against the regulations and the statute to determine whether the request meets our requirements. For example, we will review to see that per capita expenditure estimates are reasonable

and that the State has an adequate means for evaluating whether a beneficiary needs the level of care provided in an SNF or ICF. If we find the request inadequate, unrealistic, or not cost-effective, we will return the request for more or better information. If the additional information does not improve the request sufficiently, we will deny it.

F. Eligibility of Beneficiaries

Under 42 CFR 435.231, it is possible for a beneficiary who would not be eligible for Medicaid while in the community to be eligible in an institution. The regulations permit States to set a special income standard that results in a higher institutional eligibility level for institutionalized beneficiaries than the community-based eligibility level. This level cannot exceed 300 percent of the Supplemental Security Income (SSI) community-based payment standard (42 CFR 435.722 and 435.1005). Most States have chosen this option and often the institutional level is significantly higher than the community level. The purpose of current regulations, which recognize the high cost of institutional care, is to enable States, particularly those without spend down mechanisms, such as a medically needy program, to cover institutionalized individuals although their income exceeds the community-based level. However, a beneficiary may lose Medicaid eligibility if he or she leaves the institution and returns to the community. A lack of community-based supportive services and the eligibility effect of § 435.231 have combined to provide an incentive toward institutionalization.

Section 1915(c) of the Act has a target population consisting of beneficiaries who are or who would be eligible for Medicaid in an institutional setting. The statute is not explicit on how beneficiaries are to be determined eligible for new services under the waiver. However, we believe that Congress did not intend that there would be a smaller population eligible for Medicaid for home and community-based services than for institutional long-term care. In addition, the purpose of the law is to provide an incentive for beneficiaries to remain in the community by providing supportive care at home, rather than making it available to them only in an institution.

Under our regulations implementing the changes in Medicaid eligibility made by Pub. L. 97-35, "Medicaid Eligibility and Coverage Criteria", BPP-179-FC, published in the Federal Register of September 30, 1981, we decided to retain, at least for the time being, this and other optional categorically needy

groups. To keep optional categorical coverage under 42 CFR 435.231 for the institutionalized only would deprive the program and the beneficiaries who are eligible for Medicaid only because they are institutionalized of the benefits of having care provided at home and in the community, and of the savings that Congress expected would accrue from the provision of less costly noninstitutional care. Therefore, we are adding new regulations, 42 CFR 435.232, to allow States to cover individuals who would be eligible for institutional services under 42 CFR 435.231 to be eligible for home and community-based services furnished under a waiver. The new regulations, § 435.232, will affect only the base of categorically-needy beneficiaries. Medically needy individuals may become eligible under provisions of other regulations.

These new regulations, § 435.232, are very similar to § 435.231 and permit States to make eligible those categorically needy individuals in the community who—

(1) Are not eligible for SSI or a State supplement because of their income;

(2) Have income below a level specified in the plan under § 435.722;

(3) Would be eligible under § 435.231 if institutionalized; and

(4) Would require institutional care if not receiving home or community-based services authorized under the waiver.

The effect of the changes just discussed is to remove the bias in favor of institutionalization. Conversely, we do not wish to provide an inequitable incentive for those receiving noninstitutional services.

Since beneficiaries determined eligible under a special standard, such as § 435.231, have income in excess of their maintenance needs, it is reasonable to expect these beneficiaries to share in the cost of personal and medical care above a level of income protected for maintenance needs.

Current regulations at 42 CFR 435.725 and 435.733 impose this requirement on beneficiaries who are Medicaid eligible under § 431.231. Therefore, to insure equal treatment of institutionalized beneficiaries and beneficiaries receiving home and community-based services under the waiver, we will require beneficiaries who are eligible for home and community-based services under the waiver to share in the cost of the services. We believe that this requirement is supportable under the rationale of *Friedman v. Berger*, 547 F. 2d 724 (2d Cir., 1978). We are adding new §§ 435.726 and 435.735 to 42 CFR Part 435 for categorically needy beneficiaries. The sections are very similar to §§ 435.725 and 435.733, which

lay out the requirements of post-eligibility treatment of income and resources of institutionalized beneficiaries. Section 435.726 deals with beneficiaries who reside in States that provide Medicaid to all SSI beneficiaries or to all SSI beneficiaries and to State supplement beneficiaries. Section 435.735 deals with beneficiaries residing in States with more restrictive requirements than SSI.

There are two major differences in the new sections: (1) there is no provision dealing with consideration of maintenance of the beneficiary's home while he or she is an inpatient; and (2) there is no provision specifying the amount that is to be deducted from a beneficiary's total income and protected for his or her use for personal needs. Instead, there will be a provision discussing a beneficiary's maintenance allowance, which will be deducted from the total income. We are requiring this amount to be based on a reasonable assessment of need but it must not (for beneficiaries subject to the provisions of § 435.726, applicable to States covering all SSI beneficiaries) exceed the highest of:

(a) The amount of the income standard used to determine eligibility for SSI for and individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(b) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his or her own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(c) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

Our reasoning for setting these maximum levels (and those under § 435.735) for beneficiaries only is that they are the levels set under the present regulations at §§ 435.725(c)(2) and 435.733(c)(2) for maximum maintenance levels for spouses in the community. We assume that all other needs of beneficiaries under the waiver, which might otherwise require a higher income level to meet them, will be met by the supportive services furnished under the waiver.

In these regulations the allowances for a beneficiary with only a spouse at home and for a beneficiary with a family at home will be based on the same criteria that are used for beneficiaries

who are eligible for Medicaid because they are institutionalized.

A beneficiary with only a spouse will be allowed the reasonable amount for the beneficiary's maintenance, as determined above, plus a reasonable amount for maintenance of the spouse. The reasonable amount for the spouse will be based on the same criteria used to determine the allowance for the beneficiary.

The allowances for a beneficiary with a family will be the reasonable amount (as determined above) for the beneficiary, plus an additional amount for the maintenance needs of the family. The additional amount will:

- (a) Be based on a reasonable assessment of the family's financial needs;
- (b) Be adjusted for the number of family members living in the home; and
- (c) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under 42 CFR Part 435, Subpart I, for a family of the same size. See present § 435.725(c)(3).

The State must also deduct from the beneficiary's total income amounts for incurred medical expenses that are not subject to payment by a third party. These expenses include:

- (a) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and
- (b) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses. See present § 435.725(c)(4).

For beneficiaries subject to the provisions of § 435.733 (applicable to States with more restrictive requirements than SSI), the amount the beneficiary needs for maintenance will be determined in the same manner as the maintenance needs of the spouse under existing regulations at § 435.733. The spouse's needs will be determined the same as in § 435.733, as will the family's needs. Amounts for incurred medical expenses, as in § 435.733, will be deducted from total income.

G. Technical Changes

We are revising § 431.50, Statewide operation, to show that a State need not offer services under the new benefit to all beneficiaries in the State.

We are revising § 440.1, the basis and purpose statement for existing regulations on services, to show the new statutory authority for services that can be furnished under the waiver.

We are amending § 440.170(f) so that personal care services, when furnished under a waiver as home and community-based services, will not have to meet the definitions of these sections.

Finally, we are amending § 440.250, regulations on comparability of services, to provide that, if applicable under the waiver, services provided by the State need not be comparable for all individuals within a group.

Some sections of these regulations are affected by statutory provisions that are implemented by other regulations documents also being published at this time. It would be confusing to present the same section with different wording in different documents (by making, in each document, only the particular changes called for by the statutory provisions implemented by that document). In order to avoid this problem, the sections affected by more than one provision are presented in each document with all the changes required by each of the provisions of law that affect them. However, each of the changes is explained only once, in the preamble of the regulations document that implements the provision which requires that particular change.

Waiver of Proposed Rulemaking

Public Law 97-35 was enacted on August 13, 1981, and section 2176 of that law became effective on that date. In order to have regulations in place as close as possible to the effective date of the law, we must publish these regulations in final form promptly. Because of this, and because we believe that the States and a substantial number of Medicaid recipients may benefit by these regulations, we believe that publication of a notice of proposed rulemaking would be contrary to the public interest. We therefore find good cause to waive notice of proposed rulemaking and our normal 30-day delay in effective date. We will, however, consider any comments on this rule that are mailed by the date specified above in the "Dates" section and make any further changes that may be necessary. We will also respond to the comments when we make any further changes.

Impact Analysis

Executive Order 12291

The Secretary has determined that the proposed regulations do not meet the criteria for a "major rule", as defined by section 1(b) of Executive Order 12291. That is, the proposed regulations will not—

- Have an annual effect on the economy of \$100 million or more;

- Result in a major increase in costs or prices for consumers, any industries, any government agencies or any geographic regions; or

- Have significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or import markets.

Congress estimated that this provision, as it appeared in H.R. 3982, would save \$20 million in fiscal year 1982. Cost or savings estimates for the provision, as enacted, were not developed.

The costs or savings are a function of the balance between deinstitutionalization (some current residents of nursing homes could be returned to the community for less money) and new demand (some people who currently receive care from family and friends despite a medical need for nursing home care will become eligible for Medicaid outside the nursing home setting), and the number of States which choose to exercise this option. Because of these variables, we cannot estimate the cost of this program at this time.

(However, Congress indicated (H. Rept. 97-208, p. 987) that it expected the provisions concerning per capita costs to assure that aggregate costs will not be greater than they would have been without the home and community-based services). Moreover, the purpose of the legislative amendment was to provide the States with sufficient flexibility to develop more economical alternatives to the high cost of long-term care institutional services. To the extent that this purpose is achieved, then the cost of providing the home and community-based services under the waiver will offset the cost of institutional care that would otherwise have been required. Further, by facilitating the use of other providers of care, more competition should be generated. Accordingly, we do not believe the criteria for a "major rule" will be met.

Regulatory Flexibility Act

Section 604 of Public Law 96-354 (the Regulatory Flexibility Act of 1980) requires that each Federal agency prepare, and make available for public comment, a regulatory flexibility analysis on certain regulations. The regulatory flexibility analysis is intended to explain what effect regulatory actions by agencies would have on small businesses and other small entities.

As defined by the Regulatory Flexibility Act, the term "small entities"

includes "small governmental jurisdictions". The latter term is defined as local governments (cities, counties, towns, townships, villages, school districts, or other special districts) with a population of less than fifty thousand persons.

As explained above, these regulations will permit States to offer an array of services to beneficiaries outside of an institutional setting. Although they directly affect States, the regulations could indirectly adversely affect providers of institutional services that are small enough to meet the definition of "small entity", since some individuals may choose a home or community-based service rather than an inpatient service. However, we do not believe the regulations will have a significant economic effect on a substantial number of small entities. These regulations will benefit some entities that were not able to participate previously as providers under Medicaid before because the services they provide are not covered under the Medicaid program. The regulations are intended to expand the universe of small providers and may benefit them economically. Although we do not know how many States will take advantage of the provisions of these regulations, we project that the total number of providers that benefit significantly will be small compared to total number of providers. (Many providers in a position to become Medicaid providers are already reimbursed under other programs for the same services.) Therefore, the Secretary certifies, under section 805(b) of the Regulatory Flexibility Act, that the regulations will not have a significant economic impact on a substantial number of small entities.

Reporting and Recordkeeping Requirements

The Department is required to submit to the Office of Management and Budget for review and approval, 42 CFR 441.301, 441.302, 441.303 and 441.304, which include reporting and recordkeeping requirements. These sections have been submitted to OMB. We will publish a notice in the Federal Register when approval has been obtained indicating the effective date of the reporting.

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

42 CFR Part 431 is amended as follows:

The authority citation for Part 431 reads as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 431.50 is amended by revising paragraphs (a) and (c) to read as follows:

§ 431.50 Statewide operation.

(a) *Basis and purpose.* This section implements section 1902(a)(1) of the Act, which requires a State plan to be in effect throughout the State, and section 1915, which permits certain exceptions.

(c) *Exceptions.* The requirements of paragraph (b) of this section do not apply with respect to:

(1) Service offered by comprehensive health services organizations (see § 440.250(g)) of this subchapter;

(2) Services offered by rural health clinics (see § 440.20(b));

(3) Arrangements under § 431.54(d) to purchase medical services or laboratory and x-ray services (as defined in § 440.30);

(4) Lock-in or lock-out restrictions under § 431.54(e) and (f); and

(5) Services offered under a waiver with respect to home and community based services (§ 440.180).

PART 435—ELIGIBILITY IN THE STATES AND DISTRICT OF COLUMBIA

42 CFR Part 435 is amended as follows:

1. The table of contents for Part 435 is amended by adding new §§ 435.232, 435.728 and 435.735 as follows:

Subpart C—Options for Coverage as Categorically Needy

Section

435.232 Individuals receiving home and community-based services who are eligible under a special income level.

Subpart H—Financial Requirements for the Categorically Needy

435.728 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

435.735 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

2. The authority citation for Part 435 reads as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

3. Section 435.3 is amended by adding a new statutory citation at the end of the existing text as set forth below.

§ 435.3 Basis

This part implements the following sections of the Act, which state eligibility requirements and standards:

1915(c) Home or community based services.

4. A new § 435.232 is added to read as follows:

§ 435.232 Individuals receiving home and community-based services who are eligible under a special income level.

(a) If the agency provides Medicaid under § 435.231 to individuals in institutions who are eligible under a special income level, it may also cover aged, blind and disabled individuals in the community who—

(1) Because of their income, are not eligible for SSI or State supplements;

(2) Have income below a level specified in the plan under § 435.722 (See § 435.1005 for limitations on FFP in Medicaid expenditures for individuals specified in this section);

(3) Would be eligible for Medicaid under § 435.231 if institutionalized; and

(4) Will receive home and community-based services under a waiver granted under Part 441, Subpart G, of this subchapter.

5. New §§ 435.728 and 435.735 are added to read as follows:

§ 435.728 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.232 and are receiving home and community-based services furnished under a waiver of Medicaid requirements under Part 441, Subpart G of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under subpart I of this part for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid

plan, subject to reasonable limits the agency may establish on amounts of these expenses.

§ 435.735 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.232, and are eligible for home and community-based services furnished under a waiver of State plan requirements under Part 441, Subpart G of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The more restrictive income standard established under § 435.121; or

(ii) The medically needy standard for an individual.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The more restrictive income standard established under § 435.121; or

(ii) The medically needy standard for an individual.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under subpart I of this part for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

PART 440—SERVICES: GENERAL PROVISIONS

42 CFR Part 440 is amended as follows.

1. The authority citation for Part 440 reads as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 440.1 is revised to read as follows:

§ 440.1 Basis and purpose.

This subpart interprets section 1905(a) of the Act, which lists the services included in the term "medical assistance," sections 1905 (c), (d), (f), (i), and (l), which define some of those services, and section 1915(c), which lists as "medical assistance" certain home and community-based services provided under waivers under that section to individuals who would otherwise require institutionalization. It also implements sec. 1902(a)(43) with respect to laboratory services (see also §§ 447.10 and 447.342).

3. Section 440.170 is amended by revising paragraph (f) as follows:

§ 440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

(f) *Personal care services in a recipient's home.* Unless defined differently by a State agency for purposes of a waiver granted under Part 441, Subpart G of this chapter, "personal care services in a recipient's home" means services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is—

(1) Qualified to provide the services;

(2) Supervised by a registered nurse; and

(3) Not a member of the recipient's family.

4. Section 440.180 is added to read as follows:

§ 440.180 Home or community-based services.

(a) "Home or community-based services" means services that are furnished under a waiver granted under the provisions of Part 441, Subpart G of this subchapter. The services may

consist of any of the following services as defined by the agency (but not including room and board except as specifically provided for in paragraph (b) of this section):

- (1) Case management services;
- (2) Homemaker services;
- (3) Home health aide services;
- (4) Personal care services;
- (5) Adult day health services;
- (6) Habilitation services;
- (7) Respite care services;
- (8) Other services requested by the Medicaid agency and approved by HCFA as cost-effective.

(b) FFP for home community-based services described in paragraph (a) of this section is not available in expenditures for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. For purposes of this provision, "board" means three meals a day or any other full nutritional regimen and does not include meals provided as part of a program of adult day health services.

5. Section 440.250 is amended by adding new paragraphs (h) through (k) to read as follows:

§ 440.250 Limits on comparability of services.

(h) Ambulatory services for the medically needy (§ 440.220(b)) may be limited to—

- (1) Individuals under age 18; and
- (2) Individuals entitled to institutional services.

(i) Services provided under an exception to requirements allowed under § 431.54 may be limited as provided under that exception.

(j) If HCFA has approved a waiver of Medicaid requirements under § 431.55, services may be limited as provided by the waiver.

(k) If the agency has been granted a waiver of the requirements of § 440.240 (Comparability of services) in order to provide home or community-based services under § 440.180, the services provided under the waiver need not be comparable for all individuals within a group.

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

42 CFR Part 441 is amended as follows:

Subpart G, §§ 441.300–441.305 is added to read as follows:

Subpart G—Home and Community Based Services: Waiver Requirements

Sec.

441.300 Basis and purpose.

- 441.301 Contents of request for a waiver.
- 441.302 State assurances.
- 441.303 Supporting documentation required.
- 441.304 Duration of waiver.
- 441.305 Notification of termination of a waiver.

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart G—Home and Community-Based Services: Waiver Requirements

§ 441.300 Basis and purpose.

Section 1915(c) of the Act permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. Those services are defined in § 440.180 of this subchapter. This subpart describes what the Medicaid agency must do to obtain a waiver.

§ 441.301 Contents of request for a waiver.

(a) A request for a waiver under this section must consist of—

- (1) The assurances required by § 441.302 and the supporting documentation required by § 441.303;

- (2) When applicable, requests for waivers of the requirements of section 1902(a) (1) or (10) of the Act; and

- (3) A statement as to whether the agency will refuse to offer home or community-based services to any recipient because it can reasonably expect that the cost of the home or community-based services furnished to that recipient would exceed the cost of the level of care provided in an SNF or ICF (or ICF/MR if applicable).

(b) If the agency furnishes home and community-based services, as defined in § 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must:

- (1) Provide that the services are furnished—

(i) Under a written plan of care subject to approval by the Medicaid agency;

(ii) Only to recipients who are not inpatients of a hospital, SNF, ICF, or ICF/MR, and who the agency determines would require the level of care provided in an SNF or ICF (or ICF/MR, if applicable) under Medicaid (as defined in §§ 440.40 and 440.150) if not furnished these services;

- (2) Describe the qualifications of the individual or individuals who will be responsible for developing the individual plan of care;

- (3) Describe the group or groups of individuals to whom the services will be offered;

- (4) Describe the services to be furnished; and

- (5) Provide that the documentation requirements regarding individual evaluation, specified in § 441.303(c), will be met.

§ 441.302 State assurances.

HCFA will not grant a waiver under this subpart unless the Medicaid agency provides satisfactory assurances to HCFA that:

(a) Necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include adequate standards for provider participation. If the State has licensure or certification requirements for any services or for any individuals furnishing services provided under the waiver, it must assure that the standards in the licensure or certification requirements will be met.

(b) The agency will assure financial accountability for funds expended for home and community-based services, and it will maintain and make available to HHS, the Comptroller General, or their designees, appropriate financial records documenting the cost of services provided under the waiver.

(c) The agency will provide for an evaluation of the need for home and community-based care for recipients who are entitled to the level of care provided in an SNF, ICF, or ICF/MR, as defined by §§ 440.40 and 440.150 respectively, and for whom there is a reasonable indication that they might need such services in the near future.

(d) If a recipient is determined to be likely to require the level of care provided in an SNF, ICF, or ICF/MR services, the recipient or his or her representative will be informed of the feasible alternatives, if any, available under the waiver, and permitted to choose among them.

(e) The average per capita fiscal year expenditures under the waiver will not exceed the average per capita expenditures for the level of care provided in an SNF, ICF, or ICF/MR under the State plan that would have been made in that fiscal year had the waiver not been granted. These expenditures must be reasonably estimated by the agency, and the estimates must cover each year of the waiver period.

(f) The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of recipients. The information must be consistent with a data collection plan designed by HCFA.

§ 441.303 Supporting documentation required.

The agency must furnish HCFA with sufficient information to support the assurances required by § 441.302. The information must consist of the following, at a minimum:

(a) A description of the safeguards necessary to protect the health and welfare of recipients.

(b) A description of the records and information that will be maintained to support financial accountability.

(c) A description of the agency's plan for the evaluation and reevaluation of recipients, including a description of who will make these evaluations and how they will be made. The information must include a copy of the evaluation instrument to be used and provide for the maintenance of written documentation of all evaluations and reevaluations.

(d) An explanation with supporting documentation of how the agency estimated the per capita expenditures for both institutional and noninstitutional services. This information must include the estimated utilization rates and costs for institutional and noninstitutional services included in the plan.

(1) The average per capita expenditure estimate of the cost of all services, both institutional and noninstitutional, under the waiver must not exceed the average per capita expenditure of the cost of all services in the absence of a waiver. The estimates are to be based on the following equation:

$$\frac{(A \times B) + (C \times D)}{F + H} \leq \frac{G \times I + J \times K}{F + H}$$

where:

- A = the estimated number of beneficiaries who would receive the level of care provided in an SNF, ICF, or ICF/MR under the waiver.
- B = the estimated Medicaid payment per eligible Medicaid user of such institutional care.
- C = the estimated number of beneficiaries who would receive home and community-based services under the waiver or other noninstitutional alternative services included under the State plan.
- D = the estimated Medicaid payment per eligible Medicaid user of such home and community-based services.
- F = the estimated number of beneficiaries who would likely receive the level of care provided in an SNF, ICF, or ICF/MR in the absence of the waiver.
- G = the estimated Medicaid payment per eligible Medicaid user of such institutional care.
- H = the estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.
- I = the estimated Medicaid payment per eligible Medicaid user of the noninstitutional services referred to in H.
- J = the estimated Medicaid payment per eligible Medicaid user of such institutional care.
- K = the estimated Medicaid payment per eligible Medicaid user of such home and community-based services.

§ 441.304 Duration of a waiver.

(a) Except as provided in paragraph (b) of this section, a waiver of State plan requirements to provide home or community-based services approved under this section will continue for a three-year period from the date of the approval. If the agency requests it, the waiver may be extended for three years

after the initial three-year period, if HCFA's review of the prior three-year period shows that the assurances required by § 441.302 of this subpart were met.

(b) If HCFA finds that an agency is not meeting any of the requirements for a waiver contained in this subpart, the agency will be given a notice of HCFA's findings and an opportunity for a hearing to rebut the findings. If HCFA determines that the agency is not in compliance with this subpart after the notice and any hearing, HCFA will terminate the waiver.

§ 441.305 Notification of a waiver termination.

(a) If a State chooses to terminate its waiver before the three-year period is up, it must notify HCFA in writing 30 days before terminating services to recipients.

(b) If HCFA or the State terminates the waiver, the State must notify recipients of services under the waiver in accordance with § 431.210 of this subchapter and notify them 30 days before terminating services.

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program)

Dated: September 15, 1981.

Carolyn K. Davis,
Administrator, Health Care Financing
Administration.

Approved: September 24, 1981.

Richard S. Schweiker,
Secretary.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 435, 436, 440 and 441

(BHC-182-F)

Medicaid Program; Home and Community-Based Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This rule amends the interim final Medicaid regulations published on October 1, 1981 that implemented section 2176 of the Omnibus Budget Reconciliation Act of 1981. The regulations permit States to offer, under a Secretarial waiver, a wide array of home and community-based services that an individual may need to avoid institutionalization. These final regulations: (1) Provide that certain facilities must meet standards, including those established under section 1816(e) of the Social Security Act if waiver services are to be provided in the facilities; (2) revise the equation that States must use to determine the cost-effectiveness of their waiver programs; (3) clarify that these services are available, at a State's option, to both medically needy individuals and categorically needy individuals; (4) provide that all recipients who are eligible under a special income level will have their post-eligibility income treated in a comparable manner; (5) revise some aspects of the assurances and the documentation that States must provide in their waiver requests; (6) revise the effective date of an approved waiver; (7) established a federal financial participation (FFP) limit for expenditures for home and community-based services; and (8) specify the hearings procedures that apply to waiver terminations.

EFFECTIVE DATE: April 12, 1985. However, in § 441.304(a) the change specifying the effective date of an approved waiver is effective September 9, 1985. In § 441.303(g), the change requiring an independent assessment of a waiver applies only to waiver requests and requests for extensions that are received after April 12, 1985. In § 441.301(b)(6), the change requiring States to submit individual waiver requests for each target group applies only to new waiver requests that are received after April 12, 1985. Finally, the provisions discussed in section IV. of the preamble, *Applicability of Regulation Changes*, have other

effective dates as specified in section IV.

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SUPPLEMENTARY INFORMATION:**I. Background**

On October 1, 1981, we published an interim final rule with a comment period (48 FR 46332) implementing the provisions of section 2176 of Pub. L. 97-35, the Omnibus Budget Reconciliation Act of 1981. Those regulations established a waiver program under which States are reimbursed for providing home and community-based services to individuals who would otherwise require the level of care provided in a skilled nursing facility (SNF) or intermediate care facility (ICF).

II. Statutory Amendments

Section 2176 added a new section 1915(c) to the Social Security Act (Act) that authorizes the Secretary to waive certain Medicaid statutory requirements to allow a State to cover a broad array of home and community-based services provided to individuals as an alternative to institutionalization. It also provides that the Secretary may not approve the State's request for a waiver unless the State, at a minimum, provides satisfactory assurances to the Secretary that:

1. Necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of beneficiaries provided services under the waiver and to assure financial accountability for funds spent for the services;
2. The State will provide for an evaluation of the need for the inpatient services for individuals who are entitled to and who may require the level of care provided in an SNF or ICF under the State plan; and who may be eligible for care under the home and community-based waiver;
3. Any individuals who are determined to be likely to require the level of care provided in an SNF or ICF are informed of the feasible alternatives available under the waiver, and are given the choice of the inpatient services or the alternative noninstitutional services;
4. The average per capita expenditure estimated by the State in any fiscal year for medical assistance provided to these individuals under the waiver does not exceed the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for these individuals if the waiver had not been granted; and
5. The State will provide to the Secretary annually, consistent with a

data collection plan designed by the Secretary, information on the impact of the waiver on the type and amount of medical assistance provided under the State plan and on the health and welfare of its beneficiaries.

Additionally, the law specifically provides that a waiver granted under section 1915(c) of the Act may include a waiver of the requirements of sections 1902(a) (1) and (10) of the Act. Under section 1902(a)(1) of the Act, a State plan for medical assistance must be in effect throughout the State. Section 1902(a)(10) of the Act, as amended by section 2171 of Pub. L. 97-35 and section 137(b)(7) of Pub. L. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), sets forth certain Medicaid eligibility and service coverage requirements. It requires the plan to provide the same services (in amount, duration, and scope) to all categorically needy individuals and also requires that the services available to the categorically needy are not less in amount, duration, and scope than those available to medically needy beneficiaries. Under the waiver, home and community-based services do not have to be provided throughout the State. Also, a State can choose to provide home and community-based services to a limited group of eligible individuals, such as the developmentally disabled. The State is not required to provide the services to all eligible individuals who require an ICF or SNF level of care.

Waivers granted under section 1915(c) of the Act are for an initial term of three years and may be extended for additional three-year periods. The Secretary may approve waiver extensions if a State requests an extension, the extension request meets the waiver requirements for the extended period, and the Secretary determines that the State met all the assurances discussed above for the full three years of the initial waiver. Section 1915(d) of the Act, as added by section 2175 of Pub. L. 97-35 and redesignated as section 1915(e) of the Act by section 2176 of Pub. L. 97-35, provides that the Secretary shall monitor the implementation of the waivers granted to determine if the requirements of the waivers are being met. After giving the State notice and an opportunity for a hearing, the Secretary will terminate any waivers for noncompliance with the requirements.

Under the waiver, the State may exclude those individuals for whom there is a reasonable expectation that home and community-based services would be more expensive than the Medicaid services the individual would otherwise receive.

A waiver will also allow a State to provide for such services as case management, homemaker, home health aide, personal care, adult day health, habilitation, and respite care, and other services requested by the State and approved by the Secretary. The services must be consistent with plans of care that are subject to the State's approval.

Section 137(b)(7) of TEFRA added a new section 1902(a)(10)(A)(ii)(VI) to the Act that authorizes optional categorical eligibility to individuals who would be eligible under the State plan if they were in a medical institution and who would require the level of care provided in a hospital, skilled nursing facility or intermediate care facility but for the provision of home and community-based services described in section 1915(c) of the Act, the cost of which could be reimbursed under the State plan. Under this option, individuals must receive home and community-based services under a section 1915(c) waiver.

The report of the Conference Committee on Pub. L. 97-248 states that "The conference agreement makes explicit current law related to coverage of the optional categorically needy, as reflected in current regulations at 42 CFR 435.210 *et seq.* The conferees do not intend any change in current law through this recodification" (H.R. Report No. 97-760, p. 441). We have made technical revisions to the provisions of § 435.232, "Individuals receiving home and community-based services", and redesignated that section to reflect this statutory provision and to clarify that all categorically and medically needy recipients who would be eligible for Medicaid if institutionalized and who would otherwise require institutionalization, are eligible for services under this waiver. (See section III, *Regulation Changes*)

III. Regulation Changes

We received 32 comments on the interim final rule. We have considered those comments (discussed in detail in Section VI, *Public Comments*) and are making the following changes to the interim final rule.

A. Application of Section 1616(e) of the Act to Waivers

We are amending § 441.302(a) of the regulations to provide that board and care facilities must meet the standards established under section 1616(e) of the Act, if any waiver services are to be furnished in those facilities. Section 1616(e) of the Act, commonly referred to as the Keys amendment, requires States to establish and enforce safety and related standards for institutions, foster homes, or group living arrangements

where a significant number of Supplemental Security Income (SSI) recipients are residing, or are likely to reside. This amendment was enacted on October 20, 1976 by section 505(d) of Pub. L. 94-566 as a result of concern over a series of fires in board and care facilities throughout the country. It became effective on October 1, 1977.

Section 1915(c) of the Act explicitly requires that a waiver may be approved only if the State provides us with satisfactory assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries receiving the services. We received many public comments suggesting tighter standards, including a suggestion to devise national health and safety standards. While we remain committed to the principle of providing States with maximum flexibility, we also agree with the public comments suggesting the necessity of additional health and safety assurances. Accordingly, we have included the provision that States meet the requirements of section 1616(e) of the Act when home and community-based services are provided in facilities subject to the provisions of section 1616(e) of the Act. We believe this will assure some of the additional protection that we and the public believe is necessary. Since the requirement for Keys amendment certification has been in effect since 1977, we do not believe that we are imposing an undue burden on the States. Therefore, HCFA will not approve any waiver request where waiver services will be provided in facilities that are covered by section 1616(e) of the Act, unless the State provides us with copies of its standards applicable to those facilities and certifies in the waiver request that those facilities comply with applicable State standards.

For purposes of the home and community-based services regulations, we will impose the Keys amendment requirements on all facilities that are subject to the Keys amendment standards and that have residents who receive home and community-based services in such facilities (whether or not the services are provided by the facilities). Many of these facilities are primarily residential and do not provide health related services themselves. We believe the statutory provision requiring an assurance satisfactory to the Secretary that necessary safeguards have been taken to protect the health and welfare of individuals provided services under the waiver covers more than provider participation standards. We also want to minimize the possibility of States using the waiver to

circumvent Federal health and safety standards because other avenues of care are less costly.

Further, these standards must conform to the requirements of the Keys amendment as prescribed in 45 CFR Part 1397. These provisions apply to all waivers and are effective beginning 90 days after the publication date of these final regulations. Failure to comply with the Keys amendment requirements could result in termination of the waiver under § 441.304(d) (the current § 441.304(b) has been redesignated as § 441.304(d) in these final regulations).

B. Average Per Capita Expenditures

In these final regulations, § 441.303(d) has been redesignated as § 441.303(f) and revised as noted below.

The statute and current regulations provide that the State, in its waiver request, must assure us that the average per capita expenditure for individuals under the waiver does not exceed the average per capita expenditure, as reasonably estimated by the State, that would have been made under the State plan had the waiver not been granted. The following factors were provided in the interim final regulations to compute the average per capita expenditures:

A = The estimated number of beneficiaries who would receive the level of care provided in an SNF, ICF, or ICF/MR under the waiver.

B = The estimated Medicaid payment per eligible Medicaid user of such institutional care.

C = The estimated number of beneficiaries who would receive home and community-based services under the waiver or other noninstitutional alternative services included under the State plan.

D = The estimated Medicaid payment per eligible Medicaid user of such home and community-based services.

F = The estimated number of beneficiaries who would likely receive the level of care provided in an SNF, ICF, or ICF/MR in the absence of the waiver.

G = The estimated Medicaid payment per eligible Medicaid user of such institutional care.

H = The estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.

I = The estimated Medicaid payment per eligible Medicaid user of the noninstitutional services referred to in H.

The following equation was provided in the interim final regulations to

compare average per capita expenditures with and without a waiver:

$$\frac{(A \times B) + (C \times D)}{F + H} < \frac{(F \times G) + (H \times I)}{F + H}$$

We are modifying the equation in § 441.303(f)(1) by revising some of the factors used by States to determine the cost-effectiveness of their waiver programs. We are also including additional factors in the equation to allow comparison of total Medicaid costs with and without the waiver. Finally, we are substituting "expenditure" for "payment" wherever the word appears in the equation to clarify that the cost estimates required mean the cost of services provided during the waiver year, regardless of the year in which payment is actually made.

- We have revised factors A and B to clarify that the estimate pertains only to expenditures for SNF, ICF, or ICF/MR care with the waiver.

- A = The estimated number of beneficiaries who would receive the level of care provided in an SNF, ICF, or ICF/MR with the waiver.

- B = The estimated annual Medicaid expenditure for SNF, ICF, or ICF/MR care per eligible Medicaid user with the waiver.

- We have corrected factor C to limit properly the data in that factor to home and community-based services.

- C = The estimated annual number of beneficiaries who would receive home and community-based services under the waiver.

- We have revised factor D to clarify that the estimate pertains only to expenditures for home and community-based services.

- D = The estimated annual Medicaid expenditure for home and community-based services per eligible Medicaid user.

- We have revised factor G to clarify that the estimate pertains only to expenditures for SNF, ICF, or ICF/MR care in the absence of the waiver.

- G = The estimated annual Medicaid expenditure for SNF, ICF, or ICF/MR care per eligible Medicaid user in the absence of the waiver.

- We have included the word "annual" in all factor definitions to clarify that all estimates must be on an annual basis.

The following additional factors are being included in the equation used to compute the average per capita expenditures:

- A' = The estimated annual number of beneficiaries referred to in A who would receive any of the acute care services otherwise provided under the State plan.

- B' = The estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in A'.

- C' = The estimated annual number of beneficiaries referred to in C who would receive any of the acute care services otherwise provided under the State plan.

- D' = The estimated annual Medicare expenditure per eligible Medicaid user of the acute care services referred to in C'.

- F' = The estimated annual number of beneficiaries referred to in F who would

receive any of the acute care services otherwise provided under the State plan.

- G' = The estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in F'.

For purposes of the equation, acute care services means all services otherwise provided under the State plan that are neither SNF, ICF, or ICF/MR services, nor the noninstitutional, long-term care services referred to in H.

The revised equation that States must use to determine the cost-effectiveness of their waiver programs is as follows:

$$\frac{(A \times B) + (A' \times B') + (C \times D) + (C' \times D') + (H \times I)}{F + H} < \frac{(F \times G) + (H \times I) + (F' \times G')}{F + H}$$

The main difference is that under the revised formula, with the additional factors, we will be able to compare total Medicaid costs with and without the waiver.

Congress was concerned that the total of all medical assistance for services provided to individuals who would qualify for home and community-based care under the State plan not exceed on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available.

Accordingly, the statute and these regulations provide that the State, in its waiver request must assure us that the average per capita expenditure under the waiver does not exceed the average per capita expenditure, as reasonably estimated by the State that would have been made under the State plan had the waiver not been granted. Congress expected that this provision would assure that aggregate costs will not be greater than they would have been without these alternative services. (H. Rept. 97-208, p. 967)

Under the interim rules, the equation used to determine average per capita expenditures did not take into account the cost of acute care services covered under a State's plan, such as physicians services and inpatient hospital care, because we thought these kinds of services would be unaffected by the waiver. However, it was pointed out in public comments we received, and reinforced by our own analysis that the calculation of average per capita expenditures without acute care services did not provide a sufficient demonstration that total or aggregate costs would not increase. Services

covered under a waiver may be a relatively small part of the individual's total Medicaid costs. Moreover, an individual residing in the community and receiving waiver services may use more of acute care Medicaid services than he would have, had he been in a nursing home. Accordingly, we have revised the equation so that States will be asked to provide additional information that demonstrates the provision of waiver services will not result in overall expenditures in excess of those which would have been incurred absent the waiver. The cost of physician visits, hospitalization, prescription drugs, etc., that the individual would have received will be included in the States' estimates of Medicaid expenditures in addition to the cost of SNF or ICF care. States must provide estimates that demonstrate that the total aggregate medical assistance costs for these community-based care recipients will not be greater than they would have been without these alternative services.

For purposes of the equation in these final regulations, acute care services means all services otherwise provided under the State plan that are not SNF, ICF, or ICF/MR services, or the noninstitutional, long-term care services referred to in factor H of the equation.

If the State wishes to revise its estimates at some point after a waiver is approved for example, in order to adjust for an error in the estimates or for adding an unanticipated increase in the eligible population, other factors on both sides of the equation would also have to be adjusted as necessary and the comparison would be re-examined to determine if the waiver is still cost-effective. States whose waiver requests

were approved before or during the 90-day period following the publication date of these final regulations under the original formula will be evaluated under that formula if their estimates were submitted in that form. However, the revised formula will apply to any subsequent requests for extensions. Waiver requests that have not been approved by the 90th day after the publication date of these final regulations will be subject to the revised formula.

In developing the estimates of utilization necessary to complete the above computations, the State must continue to use actual data on nursing home cost and utilization and on cost and utilization of community-based services for the most recent year before the waiver takes effect. These figures must be adjusted by the State to reflect anticipated growth in the supply of nursing home beds, availability of community-based services, and inflation.

The State's experience with utilization and cost of home and community-based services provided under title XIX, title XX, and other programs should provide a useful basis for the necessary estimates. The data must be expressed in full-year terms, and it must represent unduplicated annualized recipient counts and not bed counts. The term *unduplicated* refers to unduplicated counts for each value in the formula specified at § 441.303(f). For example, a recipient who is an inpatient in a Medicaid long-term care facility on two occasions during the year and who also receives waiver services during the year, would be counted as one unduplicated recipient under formula value A and one unduplicated recipient under formula value C (and under the prime formula values as appropriate). However, when an individual is served under any single formula value category on multiple occasions during the year, he or she would only be counted as one unduplicated recipient in the applicable single formula value category. Since recipients may be counted more than once due to their particular circumstances during the year, States should supplement their estimates with data on the number of individuals who are counted in more than one formula value category.

We have also amended § 441.303(f) to explain that States must also submit documentation with their waiver requests, showing the number of beds in Medicaid certified SNFs, ICFs, and ICF/MRs by type, and evidence of the need for additional bed capacity in the absence of the waiver. States which

propose a waiver population which would exceed the capacity of presently certified beds must produce viable certificates of need and other documentation that beds would actually be built (or have been built) and would be certified absent the waiver. Where the certificate of need process is no longer in effect or no longer viable, the State must provide other convincing data that construction would actually take place or evidence of State appropriations activity.

States must also provide data that show the occupancy rates for the beds in their Medicaid certified SNFs, ICFs, and ICF/MRs by type; whether there is any excess bed capacity for these facilities by type; and if so, the number of excess beds. If the State has waiting lists for admission to these facilities, it must provide data that show the number of persons awaiting admission to each type of facility. The State must also show how long people have to wait for admission from the time they are placed on the list. States requesting a waiver of the stateliness provision (§ 431.50) that requires a State plan to be in effect throughout the State must specify the political subdivisions in which waived services will be offered.

In order to provide further assurance that the individuals who will receive home and community-based services require the level of care provided in an SNF, ICF or ICF/MR, we have added new documentation requirements under § 441.303(f)(4). These changes are a result of our experience in dealing with waiver requests and are needed to determine whether the State's estimates are reasonable. States will be required to specify in their waiver requests the number of recipients who will actually be deinstitutionalized from certified facilities as compared with those whose admissions would be deflected or diverted because they will be receiving waiver services. Where recipients are deflected, States will be required to provide a more detailed description of their evaluation and screening procedures for recipients to assure that waiver services will be restricted to persons who would otherwise receive institutional care. For example, more stringent assessment protocols or selection only after nursing home placement has been requested. States must also specify where the diverted individuals will be coming from and how many will come from each location, e.g., hospital patients awaiting SNF or ICF placement, or persons at home.

As under current rules, the State, in its waiver request, must provide HCFA with annual per capita expenditure

estimates and describe how these estimates were derived. The State must also assure HCFA that the estimates for the product of factors $C \times D$ in the computation will not be exceeded and that FFP will not be claimed for home and community-based services expenses incurred in excess of the estimates. HCFA will review all estimates very closely to determine if they are reasonable and based on statistically supportable assumptions. Further, HCFA will compare all estimates with data the State must furnish annually on its actual experience. If the approved estimates for the home and community-based services are exceeded, the waiver may be terminated. HCFA will also begin to evaluate an approved waiver after it has been in operation for 28 months, on the basis of findings made by the Health Care Financing Administration's monitoring and assessment activities, on data the State submits annually on its waiver program for the first two years of its waiver, and the results of the independent assessment of the State's waiver program. This analysis and other information will be used to determine whether an extension of the State's waiver beyond the third year is indicated.

The current regulations require States to include information on estimated utilization rates and costs for all three types of institutional groups; that is, persons who require SNF, ICF, or ICF/MR care. We have reconsidered this requirement and have decided that data on all three categories are not necessary unless the waiver request provides services to each category. For example, there is no need for a State to provide data on persons who would need SNF and ICF care if the request is limited to individuals who would otherwise require an ICF/MR level of care. Similarly, if the request does not include persons who would otherwise require an ICF/MR level of care, a State would not be required to furnish data on that group. Section 441.303(f)(3) has been added to reflect this policy.

C. Applicability of Home and Community-Based Waivers

We have revised § 435.232 and redesignated that section as § 435.217 to clarify that all States may cover, as an optional categorically needy group, individuals who would be Medicaid eligible if institutionalized and who, but for the provision of home and community-based services, would require institutionalization in an SNF, ICF, or ICF/MR facility and who will receive home and community-based

services under a waiver granted under section 1915(c) of the Act. The redesignation is necessary because §§ 435.230-435.232 relate only to aged, blind, and disabled groups of eligible individuals. The new placement in the regulations clarifies that States may include families and children in this option as well.

Section 137(b)(7) of TEFGA added a new section 1902(a)(10)(A)(ii)(VI) to the Act. This amendment did not expand, but only clarified the provisions under section 1915(c). Some commenters to the interim final rule pointed out that coverage under § 435.232 was limited to States that covered institutionalized individuals under a special income test at § 435.231.

Our revision and redesignation provides for the inclusion of individuals whose eligibility in an institutional setting would be based on requirements of either the Supplemental Security Income (SSI) program or the State's Aid to Families with Dependent Children (AFDC) program. Our revision and redesignation also permits States that have exercised the option under section 1902(f) of the Act (to use more restrictive Medicaid eligibility requirements for the aged, blind, and disabled than those used for SSI eligibility) to cover, under a home and community-based waiver, individuals who would be eligible for Medicaid under the State's more restrictive standards if they were in a medical institution.

Medicaid eligibility under § 435.217, as revised in these final regulations, is determined in accordance with State plan criteria pertaining to individuals in SNF, ICF, or ICF/MR facilities. Depending on the State plan, this could be criteria appropriate to coverage groups described at §§ 435.121, 435.132, 435.231, 435.320, and 435.330 and any other groups who are eligible only when in an institutional setting. Also, individuals described at § 435.132 (institutionalized individuals who were eligible for Medicaid in December 1973) are deemed to meet the inpatient status requirement if they are receiving home and community-based services and continue to meet the other eligibility requirements of § 435.132 besides institutionalization.

In States that choose not to elect coverage under § 435.217, services under home and community-based waivers are limited to individuals who are Medicaid eligible under other coverage groups included in the Title XIX State plan.

We are also adding a new § 436.217 to specify that Guam, Puerto Rico, and the Virgin Islands may also cover the same individuals as an optional categorically needy group.

D. Assurances

We have revised § 441.302(b) to require a State to provide HCFA with an assurance that it will arrange for an independent audit of its waiver program and make this report available to the Secretary, the Comptroller General, and their designees. We are making this revision in response to a public comment that there was a need for additional fiscal controls and oversight of the State programs, and the suggestion that a specific audit requirement be included in the regulations. This requirement may be waived by us in particular cases; for example, if the cost of the audit will exceed the estimated savings of the State's waiver program. These assurances apply to all waivers and are effective beginning 90 days after the publication date of these final regulations. States that already have approved waivers are to submit these additional assurances within this 90-day time frame.

We have revised § 441.302(e) to require that a State provide HCFA with assurance that the actual total expenditures for home and community-based services under the waiver will not exceed the agency's approved estimated expenditures and that the State will not claim FFP for expenditures exceeding the approved estimate. The agency's approved estimated expenditures are the same estimates required in the supporting documentation under § 441.303(f) and these assurances apply to each year of the waiver period. These assurances apply to all waivers and are effective beginning with services provided under the waiver 90 days after the publication date of these final regulations. States that already have approved waivers are to submit these additional assurances within this 90-day time frame.

Regarding these assurances, we have also redesignated current § 441.304(b) as § 441.304(d) and revised it to make it clear that HCFA may terminate a waiver, including those approved before the effective date of these final regulations, if it finds that actual expenditures exceed the agency's approved estimate. (See section C for a discussion of FFP limitations on estimated home and community-based expenditures which also presents the rationale for the revised assurance requirements of § 441.302(b) and (e)).

We have further revised § 441.302(e) to require States to provide HCFA with an assurance that aggregate Medicaid expenditures for all services provided to individuals under the waiver do not exceed the aggregate Medicaid

expenditures that would be incurred for these individuals in the institutional setting, in the absence of the waiver. Such services would include, for example, physician services, acute hospital services, dental care, and pharmaceutical supplies. This additional assurance is based on one of the public comments that we received on the interim final regulations and is supported by our own findings that certain acute care services may be provided more frequently (or with greater intensity) to individuals in the home and community setting than to those in the institutional setting. To the extent that this occurs, the home and community-based services would be less cost-effective than the estimates shown. Accordingly, we have also revised § 441.303(f), which contains the equation used to estimate the average per capita expenditures under the waiver, to require that such services be reflected in the State's estimates of cost and utilization.

States that already have approved waivers are to submit the additional assurance regarding aggregate Medicaid expenditures within 90 days after the publication date of these final regulations. If a State, including those with waivers approved prior to the effective date of these final regulations is found not to be in compliance with this requirement beginning 90 days after the publication date of these final regulations, HCFA may terminate the waiver. If a termination becomes necessary, HCFA will work with the State to ensure an orderly transition so that beneficiaries will not be without necessary services.

We will not grant a waiver and may terminate an existing waiver if the Medicaid agency does not provide the required satisfactory assurances within the applicable time periods.

E. Supporting Documentation

We have revised § 441.303(a) to require the State to submit a copy of the standards that it will enforce in those facilities covered by the Keys amendment when waiver services will be furnished in those facilities. We are making this revision in response to public comments that suggested closer scrutiny of the recipients' health and safety. This requirement applies to all waivers, and is effective beginning 90 days after the publication date of these final regulations. States that already have approved waivers are to submit the assurance required under § 441.302(a)(3) and a copy of the applicable standards within this 90-day time frame.

We have revised § 441.303(c) to include a requirement that the Medicaid agency furnish us with the procedures it uses to assure reevaluation of need at regular intervals. The requirement for a reevaluation was explained in the preamble to the interim final regulations (46 FR 48535) but was inadvertently omitted from the CFR text. We have included the additional requirement that it be done at regular intervals in response to a public comment. We have added a new § 441.303(d) that requires an agency to describe how it will meet the requirement that eligible beneficiaries be informed of the feasible alternatives available under the waiver and be permitted to choose either institutional services or home and community-based services. Finally, we have revised the assurance at § 441.302(d) to clarify that beneficiaries must be given the choice of *either* the institutional or home and community-based services.

We have added a new § 441.303(e) to require an agency to explain in its waiver request the post-eligibility treatment of income and resources for those individuals who are eligible under a special income level for home and community-based services. In the preamble of the interim final rule we stated that to insure equal treatment of institutionalized beneficiaries and beneficiaries receiving home and community-based services under a waiver, we would apply similar payment rules for those beneficiaries who are eligible for home and community-based services through use of a special income level. However, we inadvertently omitted from the CFR text, the information requirement that States tell us how they plan to treat the income and resources of those individuals receiving home and community-based services who are eligible under a special income level. Through this requirement, we will know more clearly how payment is being calculated (§§ 435.217, 435.726, and 435.735).

We have revised § 441.303(f) to require the State to provide the number of beds in Medicaid certified SNFs, ICFs and ICF/MRs by type, and evidence of the need for additional bed capacity in the absence of the waiver. The interim final regulations at § 441.303 required a State to furnish us with sufficient information to support all assurances, including the assurance concerning per capita expenditures. We have concluded that evidence of bed capacity is such an integral part of the agency's explanation of estimated per capita expenditures that no waiver request would be sufficient without this documentation.

States that propose a waiver population that would exceed the capacity of presently certified beds must produce viable certificates of need and other documentation that beds would actually be built (or have been built) and would be certified absent the waiver. Where the certificate of need process is no longer in effect or no longer viable the State must provide other convincing data that construction would actually take place or evidence of State appropriations activity. Accordingly, we are specifying this information as an explicit documentation element in these final regulations. States must also provide data that show the occupancy rates for the beds in their Medicaid certified SNFs, ICFs, and ICF/MRs by type; whether there is any excess bed capacity for these facilities by type; and if so, the number of excess beds. If the State has waiting lists for admission to these facilities, it must provide data that show the number of persons awaiting admission to each type of facility. The State must also show how long people have to wait for admission from the time they are placed on the list. States requesting a waiver of the statewidened provision (§ 431.50) that requires a State plan to be in effect throughout the State must specify the political subdivisions in which waived services will be offered.

This information is needed to determine whether a State would have the capacity to provide institutional care in the absence of a waiver to those individuals who will receive home and community-based services. If the State would not have adequate bed capacity to institutionalize these individuals, its estimates may be found unreasonable.

We have added a new § 441.303(f)(4) that requires States to specify the number of waiver clients actually being deinstitutionalized from certified facilities versus those diverted from admission. Where individuals are merely diverted, States must provide additional evaluation methods to assure that services will be restricted to persons who would otherwise receive institutional care. States must also specify where the diverted individuals will be coming from and how many will come from each location, e.g., hospital patients awaiting SNF or ICF placement, or persons at home. These changes are a result of our experience in dealing with waiver requests and are needed to determine whether the State's estimates are reasonable.

Finally, we have added a new § 441.303(g) that requires a State to provide for an independent assessment of its waiver program and make the

results available to HCFA prior to the end of the three-year waiver period. The assessment must evaluate the quality of care provided to recipients, access to care, and the cost-effectiveness of the waiver, and cover at least the first 24 months of the waiver period. This requirement may be waived by us in particular cases; for example, if the State's waiver program is very small (such as a model waiver) and the cost of the assessment will exceed the estimated savings of the waiver. We are making this revision to provide more information about the impact of the waiver and to assist in determining whether a State's waiver should be extended beyond the third year. These requirements apply to all waiver requests and requests for extensions that are received after April 12, 1985.

F. Duration of Waiver

We have revised § 441.304(a) to provide that after September 9, 1985, the effective date for a waiver will be established by HCFA prospectively on or after the date of approval and after consultation with the State agency. This revision is based on our program experience that most waiver requests undergo considerable revision before final approval. Accordingly, we believe that States should not commence a waiver program until all issues are resolved and we are sure that the waiver program will be operated in accordance with applicable regulations. To facilitate a smooth transition, we are retaining our current policy for waiver requests received through September 9, 1985. Our current policy provides that a waiver becomes effective on the first day that the State meets the substantive requirements for approval as determined by HCFA and continues for a three-year period from that date. A retroactive effective date, however, cannot be earlier than the first day of the quarter in which an approvable waiver request is submitted, even though a State might have met all substantive requirements before the first day of that quarter.

We have also added new §§ 441.304(b) and 441.304(c) to clarify our policy concerning renewals of existing waivers. When we receive a request to review an existing waiver, we will determine whether that request is an extension of the existing waiver or a new waiver request. In general, if a State makes significant changes in its waiver program when it requests extension of the initial waiver, we will consider the request to be a new waiver proposal. Factors that we will use to determine whether a significant change

has been made will include changes in the eligible population, services provided, service area, and statutory sections waived. If a State submits a renewal request that would add a new group to the existing group of beneficiaries covered under the waiver, we will consider it to be two requests; one as a renewal request for the existing group, and the other as a new waiver request for the new group. When a renewal request is treated as a new proposal and we formally request additional information from the State, we may extend the State's waiver as initially approved for up to 90 days, if the waiver is about to expire. If a State intends to request a renewal of an existing waiver, it must submit the request at least 90 days before the third anniversary of the effective date of the waiver.

G. FFP Limits

The limitations on FFP in expenditures for home and community-based services contained in § 440.180(b) are being expanded and redesignated as a new § 441.310. This expansion expresses the intent of Congress that program effectiveness result from State assurances required under the statute. We are making these revisions based on a public comment (with which we agree) noting that under the waiver, there are no safeguards to protect against rising total costs. Clearly, it was not the intent of Congress that the home and community-based services provisions result in an increase of Medicaid long-term care expenditures. Accordingly, we are excluding from the definition of medical assistance under the waiver, payments for any expenditures in excess of the State's estimates. FFP will thus be available in these expenditures only up to the agency's approved estimate of the total expenditures for home and community-based services under the waiver. This estimate is contained in the supporting documentation required under § 441.303(f) and is expressed as the product of the estimated annual number of beneficiaries who would receive home and community-based services under the waiver (factor C) and the estimated annual Medicaid expenditure for home and community-based services per eligible Medicaid user (factor D). This FFP limit applies to all home and community-based services provided under the waiver beginning 90 days after the publication date of these final regulations.

To provide an additional control for enforcement of health and safety standards, these final regulations exclude from the definition of medical

assistance, services provided in facilities that do not meet the standards required under § 441.302(a). Thus, FFP will not be provided for services furnished during any period in which the facilities are found, by the Secretary, not to be in compliance with the applicable State standards described in that section. All types of providers that furnish services under the waiver must meet State health and safety standards. However, to ensure that Medicaid beneficiaries receive quality care in a safe setting, we have made the FFP limit apply to all kinds of facilities where services are furnished. This includes residential facilities subject to the Keys amendment provisions, even when the facility itself does not furnish the service. This sanction applies to all facilities that are subject to health and safety requirements; facilities subject to the Keys amendment provisions and facilities subject to other State health and safety requirements. Further, this sanction applies to all waivers beginning 90 days after the publication date of these final regulations. This sanction resulted from public comments that FFP should not be provided if a facility fails to meet health and safety requirements. Finally, we note that the FFP limits regarding expenditures and the health and safety requirements apply specifically to home and community-based services. Regular Medicaid services are not affected.

H. Miscellaneous Changes

We are adding the word "legal" to the term "recipient's representative" in § 441.302(d) to clarify our original intent that a beneficiary or his or her legal representative is involved in decisions about feasible alternatives under a waiver. This change was suggested by one commenter and we agree that adding the word "legal" is necessary to clarify the intent of this provision. The term "legal" representative is not intended to imply that the representative must be an attorney, but that the representative must be designated in accordance with the laws of the State.

We have added a new § 441.306 to specify the regulations that govern the hearings procedures for States, as suggested in the public comments. The procedures described at 45 CFR Part 213 will apply to State requests for hearings on terminations. We decided to use these particular hearings procedures because States are familiar with them regarding other Medicaid provisions. The adoption of these particular hearings procedures for waiver terminations in no way implies that HCFA believes that waivers are State

plan amendments or that an adverse decision would be appealable to the United States Court of Appeals under section 1116(a)(3) of the Act.

We have revised § 440.180 to clarify that home and community-based services are those services provided under the waiver that are not otherwise provided under the State's Medicaid plan. Home and community-based services are only those services that are in addition to the Medicaid services otherwise provided under the State plan. Accordingly, States submitting waiver applications should not request authority to provide services that are already authorized under their State plan. The waiver request should seek authority only for the actual home and community-based services that will be provided under the waiver.

Although we have still not mandated that any specific form or format be used by States when submitting waiver requests, we have made an administrative change to the waiver proposal procedure. We have revised § 441.301(b) to specify that each waiver request must be limited to one of the following target groups or any subgroup thereof that the State may define:

- Aged or disabled, or both.
- Mentally retarded or developmentally disabled, or both.
- Mentally ill.

We are requiring States to submit individual waiver requests for each target group (or subgroup) to expedite the waiver review process and to avoid the need to deny a waiver request involving more than one of the three target groups when there are problems that relate only to one of those groups.

We are making several technical changes in these regulations. We are modifying the language in § 441.302(c) to reflect more accurately our original intent and the intent of the legislation that States evaluate and periodically reevaluate the recipient's need for SNF or ICF services. We are updating an obsolete citation in § 435.3 and adding paragraph headings and designations within paragraphs in § 441.302. In addition, we are clarifying in § 441.302(a) our original intent that safeguards to protect the health and welfare of recipients apply to all types of providers who provide services under the waiver.

IV. Applicability of Regulation Changes

The changes implemented by these final regulations apply to all waiver applications and are effective 30 days after the publication date of these final regulations except as noted below:

A. Keys amendment provisions—Beginning 90 days after the publication date of these final regulations these provisions apply to all waiver requests and extensions that have been approved or that will be approved. This includes both the required assurances concerning facilities subject to the Keys amendment as well as the loss of FFP (§ 441.310) for any period in which a facility subject to health and welfare requirements is found to be out of compliance with State standards.

B. Revised formula for expenditure and utilization estimates—As previously indicated in Section III.B. of the *Regulation Changes*, States whose waiver requests were approved under the original formula before or during the 90-day period following the publication date of these final regulations, will be evaluated under that formula if their cost estimates were submitted in that form. States submitting waiver requests that have not been approved during the 90-day period following the publication date of these final regulations must submit the required estimates under the revised formula. States that request an extension of a waiver that was approved before or during the 90-day period following the publication date of these final regulations must also submit the required estimates under the revised formula.

C. Limits on FFP—These final regulations provide for FFP limits when the State's estimate of total expenditures for home and community-based services are exceeded (factors C x D in the cost-effectiveness formula). This FFP limit applies to all home and community-based services provided under the waiver beginning 90 days after the publication date of these final regulations. The FFP limit will be prorated and will not be applied retroactively because States were not aware of this requirement before these final regulations.

If a State exceeds its "C x D" estimate, it may, in addition to the FFP limit, be subject to waiver termination. Beginning ninety days after the date of publication, HCFA may terminate a waiver in any case where the State exceeds its approved estimates, even if the waiver was approved prior to the publication of these final regulations.

D. Requirement that States submit individual waiver requests for each target group—This requirement, which is specified in new § 441.301(b)(6), applies only to new waiver requests that we receive after April 12, 1985.

E. Assurances—The new assurances specified in §§ 441.302(a)(1), 441.302(a)(3), 441.302(b), 441.302(e)(2), and 441.302(e)(3) apply to all waivers

and are effective beginning 90 days after the publication date of these final regulations.

F. Independent assessment—The new requirements for an independent assessment of a State's waiver program specified in § 441.303(g) apply to all waiver requests and requests for extensions that are received after April 12, 1985.

G. Duration of a waiver—Revised § 441.304(a) is effective after September 9, 1985, and applies to all waiver requests and requests for extension that are received after September 9, 1985.

V. Policy Clarifications

Since the publication of the implementing rules on October 1, 1981, several issues have arisen through internal staff discussions, outside correspondence and some waiver requests that were submitted. As a result, we are providing the following clarifications:

A. Coverage of Prevocational and Vocational Training and Educational Activities

Prevocational and vocational training and educational activities may not be provided under the home and community-based services waiver. Among other things, section 1915(c) of the Act requires that the proposed service may be provided only to individuals who would otherwise require the level of care provided in an SNF, ICF, or ICF/MR.

While many services could be construed as an aid to avoid institutionalization, we have concluded that qualifying services under section 1915(c) of the Act must be directly related to the ultimate goal of the home and community-based services; that is, enabling the recipients to accomplish those day-to-day tasks necessary for them to remain in the community and avoid institutionalization. We do not believe that prevocational and vocational training and educational activities are commonly furnished as a means of avoiding institutionalization. Individuals would not, in the absence of such services, require institutionalization. Therefore, in applying our regulations, which define home and community-based services, we have interpreted § 440.180 as excluding these services because they are not cost effective alternatives to institutionalization.

B. Deeming Methodology

The preamble of our October 1, 1981, interim final rule was silent as to the deeming of income when determining eligibility for home and community-

based services. Deeming means that the income and resources of certain persons in an individual's family are considered as the income and resources of the individual even though not actually contributed. The following discussion is provided to clarify this issue.

In general, Medicaid institutional rules are governed by the Supplemental Security Income (SSI) eligibility rules. The SSI law requires that, when an eligible couple is separated due to institutionalization of one spouse, the resources of each spouse are considered mutually available for a period of six months after the month they cease to live together; however, the income of each is considered separately during this period. After this six-month period, the resources of each spouse are no longer considered mutually available. Rather, each spouse is treated as an individual in determining SSI eligibility and only the income and resources actually contributed by one spouse to the other are considered.

When a couple is separated due to institutionalization and only one spouse is eligible for SSI, the SSI deeming rules (which do not apply to members of an eligible couple) are applicable. These rules provide that, except for actual contributions, the income and resources of the ineligible spouse are no longer deemed available to the eligible spouse beginning with the month after the month in which they cease to live together.

Following the same deeming concept, when an eligible child is separated from his parents due to institutionalization, parental income and resources are no longer deemed available to the child and so do not affect the child's SSI eligibility beginning with the month after the month in which the child ceases to live with the parents.

Most States follow the SSI rules as required in section 1902(a)(17) of the Act of institutional deeming cases. The effect is that deeming of income and resources occurs for a relatively limited time period, thus creating an institutional bias. That is, individuals who reside in an institution are able to obtain Medicaid eligibility sooner than individuals living together in the community because of institutional deeming rules.

To reduce bias towards institutionalization, HCFA issued an interim instruction (AT 82-8) in May 1982, under which States were allowed to request a waiver to employ the deeming rules that apply to persons in institutions for the eligibility group at 42 CFR 435.232—aged, blind and disabled persons who would be eligible for

Medicaid in an institution under a special income level. This eligibility group was not a statutorily mandated group but was included in the interim final regulations published on October 1, 1981. (It has been revised and redesignated in these regulations as § 435.217.) Thereafter, section 1902(a)(10) of the Act was amended by TEFRA to specifically establish a new optional categorically needy group for home and community-based services (§ 435.217 of these regulations) that incorporated the group specified under § 435.232 into the law and expanded on it. Under this new option (§ 435.217), States have the choice of electing to cover for home and community-based services those categorically or medically needy persons who would be eligible under the State's Medicaid plan if in a medical institution. (A more complete explanation of the individuals to whom this option pertains can be found in section III.C. of the preamble.)

In determining eligibility under this new optional group, States are required to employ eligibility criteria that would be employed if the individual were in a medical institution (including the institutional deeming rules). Therefore, waivers are no longer necessary to employ the institutional deeming rules for individuals covered using the special income level. States that choose to cover individuals under § 435.217 for home and community-based services must now use the institutional deeming rules for these individuals in determining whether they would be eligible for Medicaid if they were in a medical institution. If the State wishes to apply more restrictive deeming rules to these individuals it may do so by framing the scope of the population eligible for the home and community-based services waiver under section 1915(c) of the Act in a manner that employs more restrictive deeming rules (such as those used when individuals reside in the community). This is consistent with the terms of section 1902(a)(10)(A)(ii)(VT) which applies only to individuals "who will receive home and community-based services pursuant to a waiver" under section 1915(c) of the Act.

States that cover the medically needy have an option to include medically needy individuals under § 435.217 providing those individuals would qualify for Medicaid in a medical institution as medically needy at the outset of their stay in the institution. Even if they do not exercise this option, the States may choose to employ institutional deeming rules through a waiver of section 1902(a)(10)(C)(i)(III) which requires that the methodologies of

the most closely related cash assistance program be used to determine eligibility.

For groups other than those specified under § 435.217 and the medically needy, the applicable deeming rules are the rules derived from the relevant cash assistance program. For example, for SSI recipients in the community, the community deeming rules are the appropriate rules.

On September 1, 1983, we published a final rule that revised regulations at 42 CFR 435.121, 435.734, and 435.711 to reinstitute the deeming rules for categorically needy aged, blind and disabled spouses that were in effect in 1977 (47 FR 31899). The 1977 provisions prohibited section 1902(f) States from using any deeming rules that were more liberal than SSI or more restrictive than the rules in effect under the State's Medicaid plan on January 1, 1972. The 1902(f) States covering persons under the new optional categorically needy group (§ 435.217) will have to employ their institutional deeming rules. As is the case of States that have not selected the 1902(f) option, these States may apply more restrictive deeming rules (than their institutional deeming rules) for their home and community-based services populations by framing the scope of the eligible population under the section 1915(c) waiver in a manner that employs the more restrictive rules.

To assist States in utilizing the home and community-based waiver process to avoid unnecessary institutionalization and reduce expenses, a State may also submit a model waiver request in addition to or in lieu of a fuller home and community-based waiver request. Coverage under the model waiver is limited to blind and disabled children and adults who would otherwise be ineligible for Medicaid while living at home because of the SSI deeming rules. The model request relates specifically to those individuals who, as determined by the State, have or would have established eligibility for Medicaid services based on institutionalization. The sole purpose of the request is to provide authority for the State to furnish such individuals with services in the home and community setting. States are required to offer at least one home and community-based service under the model request, for example, case management services, in addition to those services that are now included in the State's Medicaid plan. Further, States are limited to a maximum of 50 cases for each model request.

We note that section 134 of TEFRA added a new section 1902(e)(3) to the Act to provide States with the Option of covering, under Medicaid, certain

disabled children age 18 or under, who are living at home. These children could also be eligible for home and community-based services under a State waiver.

VI. Public Comments

We received comments from State Medicaid agencies, public and private interest groups, Congress, and individual citizens who work in the health field. Most of the 32 commenters on the interim final rule support the concept of a waiver program for home and community-based services, although many do suggest some revision to the regulations. Some commenters want the regulations to impose additional requirements before a State can qualify for a home and community-based services waiver. Although many of the comments we received are worthwhile, we do not want to impose additional requirements unless they serve a compelling Federal interest. While many of these suggestions are not incorporated in these regulations, we do anticipate that some States may, independently, decide to adopt them. In general, we believe that Congress intended to give the States maximum flexibility in operating their waiver programs. We expect this flexibility to foster initiative and to encourage States to administer cost-effective programs that meet specific local needs.

In view of the widespread interest in the home and community-based services waiver provision, we are soliciting and will give careful consideration to any comments received from the public. Comments received will be considered and may be used as the basis for future revisions of these regulations.

Statewidehood

Comments: The statewidehood provision, 42 CFR 431.50, requires that a State plan be in effect throughout the State; however, this requirement may be waived in the context of a home and community-based waiver program. One commenter suggests that HCFA identify the specific circumstances when single community waivers will be granted rather than waivers covering the entire State. Another commenter asserts that Congressional intent was to allow only a one-time waiver of the statewidehood requirement.

Response: Section 1915(c) of the Act provides the Secretary with waiver authority to permit States to include as medical assistance (eligible for Federal financial participation) the cost of home or community-based services which meet certain conditions. Section 1915(c)(3) provides that a waiver "may

include a waiver of the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10). It further provides that the waiver "shall be for an initial term of three years and upon the request of a State, shall be extended for additional three-year periods" unless the Secretary determines that for the previous period certain assurances were not met. This language clearly suggests that the "statewideness" waiver could continue for more than the initial three year term of the waiver. Consequently, we do not believe that the Conference Committee Report's general reference.

"The conference agreement follows the House provision," should be viewed as an endorsement of the "one-time waiver of Statewideness" which was part of the House bill. See H.R. Rept. No. 97-208, p. 968. Indeed, the House bill contained specific language which provided, "During the 12-quarter period beginning on October 1, 1981, the Secretary may waive the requirement of section 1902(a)(1) as it applies to the administration of community care plans approved under this section." This three year limit in the House bill (which is consistent with the comment) was omitted from the legislation which was passed. Therefore, we do not adopt the comment, which we believe is contrary to the statute's provision for renewal of the waiver.

We also do not believe it is appropriate to identify the specific circumstances under which statewideness will be waived. Especially, because of the differences in resources among States and the constraints inherent in meeting the statutory assurances, we believe it is appropriate to evaluate statewideness waiver applications on a case by case basis.

Objective Standards for Service Packages

Comments: One commenter recommends that States be required to develop objective written standards to determine the appropriate service package for each individual within a group.

Response: We believe this is an unnecessary requirement since we already require the States to provide a written evaluation and plan of care that must be supported by appropriate documentation.

Health and Welfare Standards

Comments: Some commenters recommend additional requirements concerning the standards for services and for those who provide the services. One commenter wants clarification as to

how HCFA will ensure that all requirements are being met.

Response: Section 1915(e) of the Act specifically places the responsibility for monitoring waiver programs with the Secretary. HCFA, having the delegated authority to administer the waiver program, recognizes its obligation to ensure the establishment of necessary additional standards and compliance with all health and welfare standards required under this section of the law as well as under section 1816(e) of the Act. We believe that the regulations, as modified, contain sufficient assurances to ensure adequate compliance by virtue of the requirements for State licensure, or participation standards for all providers furnishing services under the waiver (§ 441.302(a)) and the additional FFP restriction applicable to services in facilities which do not meet the standards (§ 441.310(a)).

We do not want to limit State flexibility or initiative unnecessarily by imposing requirements that result in unnecessary and expensive administrative burdens. Therefore, we have given States as much authority as possible for establishing the standards for provider participation. Each State must develop the safeguards necessary for its particular program.

However, in light of public comments received, we have added a requirement that States must meet the standards of section 1816(e) of the Act when home and community-based services are provided in facilities that fall under the purview of that provision. Those standards apply to institutions, foster homes, or other group living arrangements where a significant number of SSI recipients are residing, or are likely to reside.

Waiver Requests—General

Comments: One commenter asks if States can submit sequential or serial waiver requests. Others recommend that all waiver requests be published in the *Federal Register* with a comment period and that the Department issue a periodic report on approved waivers.

Response: States may submit more than one waiver request. Further, we could not publish waiver requests in the *Federal Register* and still make a Secretarial decision within the statutory 90-day period (section 1915(f) of the Act). We will, however, consider publishing a periodic report in the future. We will also determine whether there are alternate ways of making this information available. Currently, we are concentrating our resources on reviewing and processing the actual waiver requests.

Termination of Waiver

Comments: Some commenters are opposed to the threat of termination of a waiver if the program is not cost-effective in one particular year. They suggest that States should be allowed to experiment and reconcile any problems over the full three-year period.

Response: We believe that a one-year period is an equitable time frame to measure compliance with the requirements of the waiver and to terminate or continue the waiver based on our findings. By law, States must provide the Secretary with information on the impact of the waiver annually, and the law authorizes us to terminate a waiver if we find non-compliance (section 1915(e) of the Act).

We have added a new § 441.306 to specify that the procedures described at 45 CFR Part 213 will apply to State requests for hearings on terminations. We chose these particular hearings procedures because States are already familiar with them regarding other Medicaid provisions.

Definitions of Services

Comments: Some commenters want Federal criteria and guidelines issued for the definitions of services. These commenters fear that the lack of uniform standards will lead to overlapping services, low quality services, and poor fiscal accountability.

Response: The legislation is intended to provide States with the flexibility to develop and implement waiver programs that meet local needs. Although we have offered suggested definitions of services in the interim final regulations (46 FR 48533), we do not believe that it is appropriate to mandate these definitions. Further, we believe that the program contains sufficient safeguards against the possible abuses that these commenters have cited.

Services—General

Comments: Many commenters suggest that we specifically list various qualifying services in the regulations to encourage States to provide them in their waiver programs. These commenters believe that this is necessary to ensure the availability of a full range of services under the waiver program.

Response: It is not necessary nor possible to list all services in the regulations. States are free to include any type of appropriate service in their programs—hospice services, home adaptations to increase safety, nutritional assessment, counselling, etc. The law does not restrict the coverage

of appropriate services as long as the State:

(1) Demonstrates that the services are cost-effective;

(2) Demonstrates that the services are necessary to avoid institutionalization;

(3) Includes and defines the services in its waiver request; and

(4) Obtains HCFA approval.

Finally, it is not appropriate for us to encourage or discourage the use of a particular service. Each State decides what combination of services is appropriate for its particular program.

Room and Board

Comments: One commenter suggests that Medicaid should pay for room and board under residential care using the six-month limitation in title XX of the Act; and that the policy for room and board should be the same for all services. The six-month limitation under title XX of the Act provides for FFP for a maximum of six months when room and board is determined to be an integral but subordinate part of another covered service. Another commenter wants the regulations to clarify that the prohibition against payment for room and board does not apply to the medical and personal care services of foster care programs.

Response: Section 1915(c)(1) of the Act specifically excludes payment for room and board under home and community-based services. As indicated in the preamble of the interim final rule, the only exception to this prohibition that is authorized by the statute is for respite care. We see no need to include in these regulations a clarification of the status of room and board in foster care programs. The prohibition against room and board in these regulations is clearly in the context of the home and community-based services waiver programs.

Cost-Effectiveness

Comments: Besides the specific categories of qualifying services, the regulations (§ 440.180) state that other services requested by the Medicaid agency can qualify if approved by HCFA as cost-effective. One commenter recommends that HCFA approval not be required for these "other services" since the statute does not contain this requirement. The commenter suggests that the statute provides that the entire plan must be cost-effective not any particular service requested by a Medicaid agency.

Response: The statute gives the Secretary broad discretion regarding the criteria that services must meet to be considered qualifying services; particularly, those services not

specifically mentioned in the legislative history. We believe it is appropriate to impose criteria for these additional services, that will ensure conformance with the statutory intent to reduce Medicaid expenditures by providing lower-cost non-institutional services under the waiver. Accordingly, we are requiring HCFA approval for "other services" on the basis of cost-effectiveness and the necessity of the service to avoid institutionalization.

Evaluation of Need

Comments: Some commenters recommend additional restrictions for the process of evaluating an individual's need for an SNF or ICF level of care. For example, one commenter wants the regulations to specify that only a State agency can perform the evaluation. One commenter wants the regulations to require periodic reassessments of the need for care. Another commenter suggested that the evaluation must include an assessment of the recipient's total needs. These commenters believe that additional restrictions will make the evaluation process more effective by maintaining uniform standards, promoting consistent application of the standards, and eliminating possible conflicts of interest in the case of private evaluations.

Response: States are required to describe their evaluation procedures and to submit their screening documents, with their waiver request. They are also required to maintain written documentation of their evaluations and to have this documentation available for review.

The Congressional intent, as evidenced by House Report No. 97-158, Vol. II, pp. 319-320, is to allow the States flexibility in the development of appropriate evaluation procedures and in their implementation. We believe that the regulations provide this flexibility. States may decide who develops and conducts the evaluation of need and they may use whatever evaluation instruments are appropriate.

While we do not believe that extensive limitations on a State's options are warranted, we do agree that a periodic reevaluation of the need for care should be explicitly required in the regulations. Section 441.302(c) has been revised accordingly. We note that those States already filing waiver requests have, in fact, provided for this reevaluation in their waiver requests. To date, all of the waiver requests we have received included a provision for a fairly complete assessment of the individual's total needs.

Plan of Care

Comments: One commenter recommends that the plan of care be developed by a physician, nurse, or licensed staff member of the facility or agency. The commenter feels that this would protect recipients against inadequate care. Others suggest that the State be allowed to review the individual case plans on a sample basis to avoid unnecessary administrative expenses, and that the waiver requests contain specific and detailed information on plans of care, services, and case management to ensure efficient, effective programs.

Response: The purpose of the regulations is to give States the maximum opportunity for innovation with a minimum of Federal intervention. Accordingly, we believe that the States should decide who is responsible for developing the plan of care. The States do not have to approve the plans in advance nor review every plan. Since the States have the authority to develop their own approval process, they can indeed choose to review plans on a sample basis. As for the information in the waiver request, the preamble of the interim final regulations discussed the general nature of the information required. However, the actual material in the waiver request must contain specific, detailed, and complete information on all services, procedures, etc.

Comments: One commenter wants to know why institutions for mental diseases (IMDs) are excluded.

Response: The Congressional Committee Reports do not discuss IMDs. Section 1915(c)(1) of the Act, however, clearly limits eligibility to persons who would require SNF or ICF level of care, the cost of which would be reimbursed under the State plan. Mentally ill persons who require SNF or ICF level of care can qualify for home and community-based services. However, individuals who are between the ages of 21 and 65 and who would otherwise receive services in a hospital, skilled nursing facility, or intermediate care facility that is an IMD are not eligible to receive services under the waiver because Medicaid coverage in IMDs is not authorized for these individuals.

Choice of Alternatives

Comments: Some commenters suggest States be required to document that beneficiaries were informed of alternatives and that beneficiaries were permitted to choose the type of service desired. Others recommend that persons in institutions be allowed to request

waiver services. One commenter recommends that "representative" be changed to "legal representative" in § 441.302(d).

Response: We agree that "representative" should be changed to "legal representative" and have revised § 441.302(d) accordingly. However, we also believe that requiring States to document that beneficiaries were informed of alternatives is unnecessary and overly burdensome. The State must assure HCFA in its waiver request that the beneficiary choice requirement will be met. We have also added a new § 441.303(d) requiring that the State furnish to HCFA a description of how the beneficiary choice requirement will be met. Further, a beneficiary can request a fair hearing if he or she is denied a choice of services.

Although the regulations state that services can be furnished only to recipients who are not inpatients, this does not preclude a State from including currently institutionalized persons as one of the groups of individuals who will be offered waiver services, if this will permit these individuals to leave the institution. This option can allow certain individuals to leave the institution and receive the necessary services in the home, at a lower cost to Medicaid.

Limitation of Costs

Comments: One commenter recommends that expenditures under the waiver be permitted to exceed the limitation of comparable, institutionalized care. The commenter states that there are many advantages in maintaining a person at home, even if it is more expensive than an institution. Other commenters are concerned about the potential for accelerating total or aggregate costs despite the average per capita limitation in the regulations. One commenter suggests that the State methodologies concerning average per capita expenditures be made part of the public record.

Response: Congress specifically included a cost limitation in the legislation. However, the legislation does provide some flexibility since the limitation is based on average per capita expenditures. This permits States to include some individuals whose maintenance costs are actually higher than the cost of comparable services in an institution.

We agree with the comment that the current requirements for a waiver do not contain adequate safeguards to protect against an increase in total Medicaid costs as a consequence of the waiver. Clearly, it was not the intent of Congress that the home and community-based services provision result in an

increase in Medicaid long-term care expenditures. Therefore, the limitations on FFP in expenditures for home and community-based services contained in § 440.180(b) are being expanded and redesignated as a new § 441.310 to express the intent of Congress that program effectiveness result from State assurances required under the statute.

Under these final regulations, FFP is available in these expenditures only up to the agency's approved estimate of the total expenditures for home and community-based services under the waiver. We have also revised § 441.302(e) to require a State to provide HCFA with an assurance that aggregate Medicaid expenditures for all services provided to individuals under the waiver do not exceed the aggregate expenditures that would be incurred for these individuals in the institutional setting, in the absence of the waiver. Also, we have revised § 441.303(f) to require a State to include all Medicaid expenditures in its computation of average per capita expenditures.

Regarding the comment on State methodologies, we believe that publication is unnecessary. This information can be requested directly from the States that have submitted waiver requests.

Annual State Reports

Comments: One commenter recommends that certain specific items be included in the information that the State must submit in the annual reports. Another recommends that the State reports be available to providers and consumers.

Response: We have developed a data collection plan that will be used by the States. The plan permits us to compare a State's actual expenditures with its estimated expenditures and determine whether the State has met its assurances. Our objective is to limit State reporting requirements as much as possible, yet assure that basic program requirements are met. As we gain experience with the annual reports, we may wish to request some of the specific items that the commenter suggested.

Regarding the availability of State reports, providers and consumers could request this information directly from the State. Copies of State reports will also be subject to disclosure under the Freedom of Information Act.

Computation of Average Per Capita Expenditures

Comments: Some commenters suggest that States be permitted to use their own methods of computing average per capita expenditures, as long as they are able to demonstrate that the aggregate

cost of long-term care will be reduced. Others suggested that other items such as State administrative costs be considered in the computation.

Response: As previously discussed in section III.B. of this preamble, we have made various revisions to the computation. We believe that the computation in the regulations is an appropriate reflection of Congressional intent. We also believe that it is necessary for all States to use the same computation method to meet this particular legislative requirement. To monitor the waiver programs effectively, HCFA must have the necessary information from each State in a consistent format.

The computation for average per capita expenditures should include only those cost items specifically relating to medical assistance that is covered under the Medicaid program. Cost items that may have an indirect relationship to covered medical assistance cannot be considered in the computation. We agree that items such as the following should be part of the computation—

- Cost of patients in hospital awaiting nursing home or community care placements; and
- Reduced community Medicaid costs—An agency that has other means available to cover certain services may decide not to provide these services (for example, reimbursement for prescription drugs) under the Medicaid waiver, thus lowering the average per capita cost under the waiver.

We do not believe that items such as the following should be included—

- Average per capita State agency administrative cost—These costs would generally be the same whether they were incurred in connection with institutional care or home and community-based services and would not affect the computation of per capita expenditures. Therefore, it is not necessary that they be included in the computation;

- Certain in-home costs that are part of institutional costs—Costs attributable to individuals who are not currently covered by Medicaid and who are in the home, waiting for admission to an institution. We do not at this time propose that such services be reflected in the State's estimates of cost and utilization. We believe this would result in an unnecessary burden to the States since we do not know precisely the incidence or potential cost of such an occurrence. (We will be able to develop this information more fully once we determine the impact of the waivers by analyzing the annual reports that the States must submit.) However, we do

believe that an assurance is needed from the State that the aggregate costs of all services furnished to an individual in the home or community setting will not exceed the aggregate costs that would be incurred by the individual in the institutional setting, in the absence of the home and community-based waiver. Accordingly, we have amended § 441.302(e) to require such an assurance; and

- Medicare savings—For example, when a covered individual can be discharged from a hospital to a community setting rather than remaining in the hospital to await an available bed in a long-term care institution. It is not appropriate to consider Medicare saving in the computation. The statute provides that the State's estimate of average per capita expenditures is to be limited to the cost of Medicare services.

VII. Impact Analysis

Executive Order 12291

We have determined that neither the October 1, 1981 interim final regulations nor these final regulations meet the criteria for a "major rule", as defined by section 1(b) of Executive Order 12291. That is, neither will—

- Have an annual effect on the economy of \$100 million or more;
- Result in a major increase in costs or prices for consumers, any industries, any government agencies or any geographic regions; or
- Have significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or import markets.

Our actuaries cannot estimate the economic effect caused by these provisions due to the uncertainties regarding the number of States that will ultimately apply for waivers; the number of waivers that will be requested; the nature of the waivers; and whether the waivers will result in reduced costs or the provision of more services for the same costs.

The costs or savings resulting from these provisions are a function of the balance between deinstitutionalization (some current residents of nursing homes could be returned to the community for less money) and new demand (some people who currently receive care from family and friends despite a medical need for nursing home care will become eligible for Medicaid outside the nursing home setting), and the number of States that choose to exercise the option. Congress indicated (H.R. Report No. 97-208, p. 967) that it

expected the provisions concerning per capita costs would assure that aggregate costs are not greater than what they would have been without the home and community-based services. Moreover, the purpose of the legislative amendment was to provide the States with sufficient flexibility to develop more economical alternatives to the high cost of long-term care institutional services. To the extent that this purpose is achieved, the cost of providing the home and community-based services under the waiver will offset the cost of institutional care that would otherwise have been required. Further, by facilitating the use of other providers of care, more competition should be generated.

Regulatory Flexibility Act

The Secretary certifies under 5 U.S.C., 605(b) enacted by the Regulatory Flexibility Act (Pub. L. 96-354), that neither the interim final regulations nor these final regulations, which amend and clarify the interim regulations, will result in a significant economic impact on a substantial number of small entities.

The primary impact of the interim final and these final regulations is on the States and beneficiaries, which are not "small entities" within the meaning of the Act. Any impact upon providers will be the result of individual State decisions, as developed in the waiver requests. We would encourage States that are developing waiver requests under these provisions, to consider their effect on small entities and to analyze alternative choices. We believe that States are best qualified to determine whether a given adverse effect on small entities is appropriate in view of the benefits offered by a waiver request that is consistent with the provisions of these regulations.

Further, in view of the provisions of section 1915 of the Act, while a State may consider the effect on small entities before submitting a request, we do not consider this effect in reviewing these requests. Therefore, a regulatory flexibility analysis is not required.

Reporting and Recordkeeping Requirements

Sections 441.302 and 441.303 contain reporting and recordkeeping requirements that are subject to the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3507). As required by that act, HCFA requested Office of Management and Budget (OMB) approval of these requirements. OMB has approved the data collection plan requirement in § 441.302.

The OMB approval number for the data collection plan required by § 441.302 is 0938-0268. The OMB approval number for the requirements under the model waiver request that States have the option of submitting is also 0938-0268. (The model waiver request is discussed in Part V. of the preamble, *Policy Clarifications*.)

The other reporting and recordkeeping requirements contained in §§ 441.302 and 441.303 are not effective until OMB approves them. We will publish a notice in the Federal Register when approval is obtained from OMB, giving the OMB approval number and the effective date of the requirements.

List of Subjects

42 CFR Part 435

Aid to Families with Dependent Children, Aliens, Categorically needy, Contracts (Agreements—State Plan), Eligibility, Grant-in-Aid program—health, Health facilities, Medicaid, Medically needy, Reporting and recordkeeping requirements, Spend-down, Supplemental security income (SSI).

42 CFR Part 436

Aid to Families with Dependent Children, Aliens, Contracts (Agreements) Eligibility, Grant-in-Aid program—health, Guam, Health facilities, Medicaid, Puerto Rico, Supplemental security income (SSI), Virgin Islands.

42 CFR Part 440

Clinics, Dental health, Drugs, Grant-in-Aid program—health, Health care, Health facilities, Health professions, Hearing disorders, Home health services, Inpatients, Laboratories, Language disorders, Lung diseases, Medicaid, Mental health centers, Occupational therapy, Personal care services, Physical therapy, Prosthetic devices, Outpatients, Ophthalmic goods and services, Rural areas, Speech disorders, X-rays.

42 CFR Part 441

Abortions, Aged, Early Periodic Screening Diagnosis and Treatment (EPSDT), Family Planning, Grant-in-Aid program—health, Health facilities, Infants and children, Institutions for mental diseases (IMD), Kidney diseases, Maternal and child health, Medicaid, Mental health centers, Ophthalmic goods and services, Penalties, Psychiatric facilities, Sterilizations.

42 CFR Part 435, 436, 440 and 441 are amended as follows:

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA AND THE NORTHERN MARIANA ISLANDS

The authority citation for Part 435 reads as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

A. 42 CFR Part 435 is amended as follows:

1. a. In the table of contents under Subpart C, Options for Coverage as Categorically Needy, a new § 435.217—"Individuals receiving home and community-based services," is added under the center headings, *Options for Coverage of Families and Children and the Aged, Blind, and Disabled*.

b. Also, § 435.232 is removed.
2. Section 435.3 is amended by revising the last citation of 1902(a) to read as follows:

§ 435.3 **Basis**
* * *

1902(a) (second paragraph after (44))
Eligibility despite increased monthly insurance benefits under title II.
* * *

§ 435.232 [Redesignated as § 435.217]
3. Section 435.232 is redesignated as § 435.217 and revised to read as follows:

§ 435.217 **Individuals receiving home and community-based services.**

The agency may provide Medicaid to any group or groups of individuals in the community who—

- (a) Would be eligible for Medicaid if institutionalized;
- (b) Would require institutionalization in the absence of home and community-based services under a waiver granted under Part 441, Subpart G, of this subchapter; and
- (c) Receive the waived services.

§§ 435.726 and 435.735 [Amended]

4. Sections 435.726(b) and 435.735(b) are amended by removing the reference to "§ 435.232" and inserting "§ 435.217" in its place.

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

The authority citation for Part 436 reads as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

B. 42 CFR Part 436 is amended as follows:

1. In the table of contents under Subpart C, *Options for Coverage as Categorically Needy*, a new § 436.217—"Individuals receiving home and

community-based services," is added under the center heading.

Options for Coverage of Families and Children and the Aged, Blind, and Disabled

2. A new § 436.217 is added to read as follows:

§ 436.217 **Individuals receiving home and community-based services.**

(a) The agency may provide Medicaid to any group or groups of individuals in the community who—

- (1) Would be eligible for Medicaid if institutionalized;
- (2) Would require institutionalization in the absence of home and community-based services under a waiver granted under Part 441, Subpart G, of this subchapter; and
- (3) Receive the waived services.

PART 440—SERVICES: GENERAL PROVISIONS

The authority citation for Part 440 reads as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302), unless otherwise noted.

42 CFR Part 440 is amended as follows:

C. Section 440.180 is amended by removing the paragraph designation for paragraph (a) and revising the contents of that paragraph. Paragraph (b) is revised and redesignated as § 441.310. As revised § 440.180 reads as follows:

§ 440.180 **Home or community-based services.**

"Home or community-based services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of Part 441, Subpart G of this subchapter. Except as provided in § 441.310 the services may consist of any of the following services as defined by the agency that meet the standards specified in § 441.302(a):

- (a) Case management services;
- (b) Homemaker services;
- (c) Home health aide services;
- (d) Personal care services;
- (e) Adult day health services;
- (f) Habilitation services;
- (g) Respite care services;
- (h) Other services requested by the Medicaid agency and approved by HCFA as cost-effective.

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

The authority citation for Part 441 reads as follows:

Authority: Sec. 1102 of the Social Security Act. (42 U.S.C. 1302).

D. 42 CFR Part 441 is amended as follows:

1. The Table of Contents for Part 441 is amended by adding new §§ 441.306 and 441.310 as follows:

Subpart G—Home and Community-Based Services: Waiver Requirements
* * *

Sec. 441.306 **Hearings procedures for waiver terminations.**

441.310 **Limits on Federal financial participation (FFP).**
* * *

2. Section 441.301 is amended by revising paragraphs (b)(4) and (5), and adding a new paragraph (b)(6) to read as follows (the introductory language of paragraph (b) is reprinted without change for the convenience of the reader):

§ 441.301 **Contents of request for a waiver.**
* * *

(b) If the agency furnishes home and community-based services, as defined in § 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must:

(4) Describe the services to be furnished;

(5) Provide that the documentation requirements regarding individual evaluation, specified in § 441.303(c), will be met; and

(6) Be limited to one of the following target groups or any subgroup thereof that the State may define:

- (i) Aged or disabled, or both.
- (ii) Mentally retarded or developmentally disabled, or both.
- (iii) Mentally ill.

3. Section 441.302 is revised to read as follows:

§ 441.302 **State assurances.**

HCFA will not grant a waiver under this subpart and may terminate a waiver unless the Medicaid agency provides the following satisfactory assurances to HCFA:

(a) *Health and Welfare*—Assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include—

(1) Adequate standards for all types of providers that provide services under the waiver;

(2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and

(3) Assurance that all facilities covered by section 1816(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

(b) *Financial accountability.*—The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

(c) *Evaluation of need.*—Assurance that the agency will provide for an evaluation (and periodic reevaluations) of the need for the level of care provided in an SNF, ICF, or ICF/MR, as defined by §§ 440.40 and 440.150, respectively, when there is a reasonable indication that individuals might need such services in the near future but for the availability of home and community-based services.

(d) *Alternatives.*—Assurance that when a recipient is determined to be likely to require the level of care provided in an SNF, ICF, or ICF/MR, the recipient or his or her legal representative will be—

(1) Informed of any feasible alternatives available under the waiver; and (2) given the choice of either institutional or home and community-based services.

(e) *Expenditures.*—Assurance that—(1) The average per capita fiscal year expenditures under the waiver will not exceed the average per capita expenditures for the level of care provided in an SNF, ICF, or ICF/MR under the State plan that would have been made in that fiscal year had the waiver not been granted. (i) These expenditures must be reasonably estimated by the agency; and (ii) The estimates must be annualized and must cover each year of the waiver period.

(2) The agency's actual total expenditures for home and community-based services under the waiver and its claim for FFP in expenditures for the services will not exceed the agency's approved estimates for these services, expressed as the product of (C×D) in the supporting documentation required under § 441.303(f), for each year of the waiver period.

(3) The agency's actual total expenditures for home and community-

based and other Medicaid services provided to individuals under the waiver will not, in any year of the waiver period, exceed the amount that would be incurred by Medicaid for these individuals in an SNF, ICF, or ICF/MR, in the absence of a waiver.

(f) *Reporting.*—Assurance that annually, the agency will provide HCFA with information on the waiver's impact. The information must be consistent with a data collection plan designed by HCFA and must address the waiver's impact on—

(1) The type, amount, and cost of services provided under the State plan; and

(2) The health and welfare of recipients.

4. Section 441.303 is amended by revising and redesignating paragraph (d) as paragraph (f), adding new paragraphs (d), (e), and (g), and revising paragraphs (a) and (c), as follows:

§ 441.303 Supporting documentation required.

The agency must furnish HCFA with sufficient information to support the assurances required by § 441.302. Except as HCFA may otherwise specify for particular waivers, the information must consist of the following, at a minimum:

(a) A description of the safeguards necessary to protect the health and welfare of recipients. This information must include a copy of the standards established by the State for facilities that are covered by section 1816(e) of the Act.

(c) A description of the agency's plan for the evaluation and reevaluation of recipients, including—(1) A description

of who will make these evaluations and how they will be made; (2) A copy of the evaluation instrument to be used; (3) The agency's procedure to ensure the maintenance of written documentation on all evaluations and reevaluations; and (4) The agency's procedure to ensure reevaluations of need at regular intervals.

(d) A description of the agency's plan for informing eligible recipients of the feasible alternatives available under the waiver and allowing recipients to choose either institutional services or home and community-based services.

(e) An explanation of how the agency will apply the applicable provisions regarding the post-eligibility treatment of income and resources of those individuals receiving home and community-based services who are eligible under a special income level (included in § 435.217 of this chapter).

(f) An explanation with supporting documentation satisfactory to HCFA of how the agency estimated the per capita expenditures for services. This information must include but is not limited to the estimated utilization rates and costs for services included in the plan, the number of actual and projected beds in Medicaid certified SNFs, ICFs, and ICF/MRs by type, and evidence of the need for additional bed capacity in the absence of the waiver.

(1) The annual average per capita expenditure estimate of the cost of home and community-based and other Medicaid services under the waiver must not exceed the annual average per capita expenditures of the cost of services in the absence of a waiver. The estimates are to be based on the following equation:

$$\frac{(A \times B) + (A' \times B') + (C \times D) + (C' \times D') + (H \times I)}{F + H} < \frac{(F \times G) + (H \times I) + (F \times G')}{F + H}$$

where:

A = the estimated annual number of beneficiaries who would receive the level of care provided in an SNF, ICF, or ICF/MR with the waiver.

B = the estimated annual Medicaid expenditure for SNF, ICF, or ICF/MR care per eligible Medicaid user with the waiver.

C = the estimated annual number of beneficiaries who would receive home and community-based services under the waiver.

D = the estimated annual Medicaid expenditure for home and community-based services per eligible Medicaid user.

F = the estimated annual number of beneficiaries who would likely receive the level of care provided in an SNF, ICF, or ICF/MR in the absence of the waiver.

G = the estimated annual Medicaid expenditure per eligible Medicaid user of such institutional care in the absence of the waiver.

H = the estimated annual number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.

I = the estimated annual Medicaid expenditure per eligible Medicaid user of the noninstitutional services referred to in H.

A' = the estimated annual number of beneficiaries referred to in A who would receive any of the acute care services otherwise provided under the State plan.
 B' = the estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in A'.
 C' = the estimated annual number of beneficiaries referred to in C who would receive any of the acute care services otherwise provided under the State plan.
 D' = the estimated annual Medicaid expenditure per eligible Medicaid user of acute care services referred to in C'.
 F' = the estimated annual number of beneficiaries referred to in F who would receive any of the acute care services otherwise provided under the State plan.
 G' = the estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in F'.

(2) For purposes of the equation, acute care services means all services otherwise provided under the State plan that are neither SNF, ICF, or ICF/MR services, nor the noninstitutional, long-term care services referred to in H.

(3) Data on the estimated annual number of beneficiaries and expenditures for those who would otherwise receive an SNF, ICF, or ICF/MR level of care is required for all three types of institutions only if the waiver request provides that each of these groups will be offered home and community-based services. For example, if the request does not include persons who would otherwise receive an ICF/MR level of care, the State is not required to furnish data on that group.

(4) The data must show the estimated annual number of beneficiaries who will be deinstitutionalized from certified SNFs, ICFs and ICF/MRs because they would receive home and community-based services under the waiver, and the estimated annual number of beneficiaries whose admission to such institutions would be diverted or deflected because of the waiver services. For the latter group, the State's evaluation process required by § 441.303(c) must provide for a more detailed description of their evaluation and screening procedures for recipients to assure that waiver services will be limited to persons who would otherwise receive the level of care provided in an SNF, ICF, or ICF/MR.

(g) Except as HCFA may otherwise specify for particular waivers, the agency must provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-effectiveness. The results of the assessment must be submitted to HCFA at least 90 days prior to the third anniversary of the approved waiver period and cover at least the first 24 months of the waiver.

5. Section 441.304 is revised as follows:

§ 441.304 Duration of a waiver.

(a) The effective date for a waiver of Medicaid requirements to provide home and community-based services approved under this subpart is established by HCFA prospectively on or after the date of approval and after consultation with the State agency.

The waiver continues for a three-year period from the effective date. If the agency requests it, the waiver may be extended for additional three-year periods. If HCFA's review of the prior three-year period shows that the assurances required by § 441.302 of this subpart were met.

(b) HCFA will determine whether a request for extension of an existing waiver is actually an extension request or a request for a new waiver.

(1) Generally, if a State's extension request proposes a change in services provided, eligible population, service area, or statutory sections waived, HCFA will consider it a new waiver request.

(2) If a State submits an extension request that would add a new group to the existing group of beneficiaries covered under the waiver, HCFA will consider it to be two requests: one as an extension request for the existing group, and the other as a new waiver request for the new group.

(c) HCFA may grant a State an extension of its existing waiver for up to 90 days to permit the State to document more fully the satisfaction of statutory and regulatory requirements needed to approve a new waiver request. HCFA will consider this option when it requests additional information on a new waiver request submitted by a State to extend its existing waiver or when HCFA disapproves a State's request for extension.

(d) If HCFA finds that an agency is not meeting any of the requirements for a waiver contained in this subpart, the agency will be given a notice of HCFA's findings and an opportunity for a hearing to rebut the findings. If HCFA determines that the agency is not in compliance with this subpart after the notice and any hearing, HCFA may terminate the waiver. For example:

(1) If HCFA finds that the agency's actual total expenditures for home and community-based services under the waiver exceed the agency's approved estimates for these services, expressed as the product of (C × D) in the supporting documentation required under § 441.303(f), for any year of the waiver period, the waiver may be terminated; or

(2) The waiver may be terminated if HCFA finds that the agency's actual total expenditures for home and community-based and other Medicaid services provided to individuals under the waiver exceed, for any year of the waiver period, the amount that would be incurred by Medicaid for these individuals in an SNF, ICF, or ICF/MR, in the absence of a waiver.

6. A new § 441.306 is added to read as follows:

§ 441.306 Hearings procedures for waiver terminations.

The procedures specified at 45 CFR Part 213 are applicable to State requests for hearings on terminations.

7. A new § 441.310 is added to read as follows:

§ 441.310 Limits on Federal financial participation (FFP).

(a) FFP for home and community-based services listed in § 440.180 of this chapter is not available in expenditures for—

(1) Services provided in a facility subject to the health and welfare requirements described in § 441.302(a) during any period in which the facility is found not to be in compliance with the applicable State standards described in that section;

(2) Home and community-based services that exceed the agency's approved estimated total expenditures for these services, expressed as the product of (C × D) in the supporting documentation required under § 441.303(f) for each year of the waiver period; and

(3) The cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. For purposes of this provision, "board" means three meals a day or any other full nutritional regimen and does not include meals provided as part of a program of adult day health services.

(b) On or after June 11, 1985, the limits specified in paragraphs (a)(1) and (a)(2) of this section are applicable to all existing and future waiver programs under this part.

(Catalog of Federal Assistance Program No. 13.714, Medical Assistance Program)

Dated: November 28, 1984.

Carolyn K. Davis,
Administrator, Health Care Financing Administration.

Approved: January 7, 1985.

Margaret M. Heckler,
Secretary.

[FR Doc. 85-5715 Filed 3-12-85; 8:45 am]

BILLING CODE 4120-01-M

ATTACHMENT C. House and Senate provisions on home and community-based care under the Omnibus Budget Reconciliation Act of 1981. (H.R. 3982, House budget reconciliation bill, June 19, 1981--legislative and report language on "Options for the provision of home and community-based care and requirements of preadmission;" S. 1377, Senate budget reconciliation bill, June 17, 1981--legislative and report language on "Nonmedical services for certain individuals."

Calendar No. 188

97TH CONGRESS
1ST SESSION

H. R. 3982

IN THE SENATE OF THE UNITED STATES

JULY 7, 1981

Received under authority of the order of the Senate of June 25 (legislative day, June 1), 1981

JULY 8, 1981

Placed on the calendar

AN ACT

To provide for reconciliation pursuant to section 301 of the first concurrent resolution on the budget for the fiscal year 1982.

1 *Be it enacted by the Senate and House of Representatives of the United States*
2 *of America in Congress assembled,*

3 SHORT TITLE

4 SECTION 1. This Act may be cited as the "Omnibus Budget Reconciliation
5 Act of 1981".

6 PURPOSE

7 SEC. 2. It is the purpose of this Act to implement the recommendations which
8 were made by specified committees of the House of Representatives pursuant to
9 directions contained in section 301 of the first concurrent resolution on the
10 budget for the fiscal year 1982 (H. Con. Res. 115, 97th Congress), and pursuant
11 to the reconciliation requirements which were imposed by such concurrent resolu-
12 tion as provided in section 310 of the Congressional Budget Act of 1974.

13 TITLE I—HOUSE COMMITTEE ON 14 AGRICULTURE

15 Subtitle A—Food Stamp Program Reductions and
16 Other Reductions in Authorizations for Appropriations

17 FOOD STAMP PROGRAM REDUCTIONS

18 HOUSEHOLD DEFINITION

19 SEC. 1001. Section 3(i) of the Food Stamp Act of 1977 is amended—

1 PERMITTING MEDICAID MATCHING FOR PAYMENTS TO PROMOTE CLOSING
2 AND CONVERSION OF UNDERUTILIZED HOSPITAL FACILITIES

3 SEC. 6328. (a) Section 1902 of the Social Security Act is amended by adding
4 after subsection (k), added by section 6326 of this subchapter, the following new
5 subsection:

6 "(1)(1) Except as provided in paragraph (2), a State may include, as a cost with
7 respect to hospital services under its plan under this title, periodic expenditures
8 made to assist hospitals (other than those located in, or serving residents of,
9 underserved areas) in (A) eliminating excess bed capacity, (B) discontinuing an
10 underutilized service for which there are adequate alternative sources in the area,
11 or (C) substituting for the underutilized service some other service which is
12 needed in the area, except that, with respect to the closure of a hospital, such
13 expenditures may be in the form of a lump-sum payment where such payment
14 would constitute a more efficient and economic alternative to periodic expendi-
15 tures.

16 "(2) No such expenditures may be included unless—

17 "(A) in the case of a State that has a State statutory program for re-
18 duction of the number of hospital beds in the State, such expenditures are
19 consistent with such program, and

20 "(B) fair and equitable arrangements have been made to protect the in-
21 terests of employees affected by any discontinuance of hospital services
22 against worsening of their positions with respect to their employment, in-
23 cluding arrangements to preserve the rights and benefits of such employees
24 and to provide retraining.

25 "(3) To the extent that the Secretary determines that such expenditures are
26 reasonable in relation to the savings achieved under this title and under title
27 XVIII through the reduction of hospital services, the limitation on reimburse-
28 ment for inpatient hospital services under subsection (a)(13)(D)(i) to the reason-
29 able cost of such services (as determined for purposes of title XVIII) shall not
30 apply to such expenditures."

31 (b) The amendments made by subsection (a) shall apply to expenditures made
32 to hospitals on or after October 1, 1981.

33 OPTIONS FOR THE PROVISION OF HOME AND COMMUNITY-BASED CARE AND
34 REQUIREMENT OF PREADMISSION SCREENING FOR LONG-TERM CARE
35 PATIENTS

36 SEC. 6329. (a) Title XIX of the Social Security Act is amended by adding at
37 the end the following new section:

38 "STATE COMMUNITY CARE PLAN

39 "SEC. 1915. (a) A State with a plan approved under this title may apply to the
40 Secretary to have Federal payments made for comprehensive assessments and for
41 services described in subsection (b)(2) for which payment may not otherwise be

1 made under the plan. The Secretary may not approve such an application
2 unless—

3 “(1) the application is accompanied by a plan for assessments for long-
4 term care services and for the provision of medical assistance under this
5 title with respect to some or all of the care and services described in sub-
6 section (b)(2)(B),

7 “(2) such plan meets the requirements of subsection (b), and

8 “(3) the State provides the Secretary with satisfactory assurances that
9 the implementation of such plan will not result in a level of expenditures
10 for institutional and noninstitutional long-term care services (including
11 services described in subsection (b)(2)(B)) under the State plan under this
12 title above the level of such expenditures if the plan under this section
13 were not approved.

14 Assurances referred to in paragraph (3) may include an agreement, between the
15 State and the Secretary, providing a limitation on the amount of expenditures
16 that may be recognized, for purposes of payment to the State under section
17 1903(a) with respect to long-term care services, during a quarter or fiscal year.

18 “(b) The requirements referred to in subsection (a)(2) are that the plan under
19 this section will provide as follows:

20 “(1)(A) The State will provide for a timely comprehensive assessment of
21 each individual who is eligible or applying for assistance under the State
22 plan and who is in need of long-term skilled nursing facility or intermedi-
23 ate care facility services under the plan.

24 “(B) Except in the case of individuals residing in a health manpower
25 shortage area (designated under section 332 of the Public Health Service
26 Act) and such other special circumstances as the Secretary may approve,
27 such an assessment may not be made by a non-public entity which—

28 “(i) directly or indirectly provides or benefits from the provision of
29 home health care or skilled nursing facility or intermediate care facili-
30 ty services under this title, or

31 “(ii) is a person with an ownership or control interest (as defined in
32 section 1124(a)(3)) in, or has a contract to provide services with re-
33 spect to, a home health agency, skilled nursing facility, or intermedi-
34 ate care facility that provides services under this title.

35 “(C) Such an assessment shall consist of a direct, personal assessment,
36 by trained individuals, of all factors (which may include, among others, fi-
37 nancial resources, medical, psychological, and social needs, architectural
38 barriers and other environmental factors, family and community support,
39 and ability to live independently with appropriate in-home services) relat-
40 ing to the likelihood of the individual's requiring long-term skilled nursing

1 facility or intermediate care facility services, and such assessment shall de-
 2 termine whether or not the individual is in need of such services.

3 "(D) The individual shall be informed of such determination and, if de-
 4 termined to be in need of long-term skilled nursing facility or intermediate
 5 care facility services, shall be informed of the feasible alternatives, availa-
 6 ble at the choice of the individual, to the provision of such services.

7 "(2) With respect to individuals determined pursuant to a comprehensive
 8 assessment under paragraph (1) to be in need of long-term skilled nursing
 9 facility or intermediate care facility services and for whom the furnishing
 10 of medical assistance with respect to the services described in subpara-
 11 graph (B) of this paragraph is a feasible alternative to such assistance with
 12 respect to long-term skilled nursing facility or intermediate care facility
 13 services—

14 "(A) the State plan will provide for the development (either by the
 15 persons preparing the assessment described in paragraph (1) or by
 16 others under arrangements made by the State) of a written plan of
 17 care for the provision of services to the individual (which plan is ap-
 18 proved, and periodically reviewed, by the State or by others under
 19 contract with the State);

20 "(B) the State plan will provide for making medical assistance
 21 available, pursuant to such plan, with respect to—

22 "(i) case-management services,

23 "(ii) nursing services on a part-time, intermittent, or short-
 24 term full-time basis,

25 "(iii) homemaker/home health aide services and personal care
 26 services,

27 "(iv) medical supplies, equipment, and appliances suitable for
 28 use in the home,

29 "(v) physical therapy, occupational therapy, and speech pa-
 30 thology and audiology services,

31 "(vi) adult day health and habilitation services,

32 "(vii) respite care, and

33 "(viii) other services requested by the State and approved by
 34 the Secretary,

35 furnished by providers who meet such standards (including State li-
 36 censure, where applicable and appropriate) and enter into such par-
 37 ticipation agreement with the State as the State establishes (in ac-
 38 cordance with regulations of the Secretary), without limitation as to
 39 amount, duration, or scope, except that the State may establish a
 40 dollar limit on the total amount of medical assistance provided with

1 respect to such services for an individual for any 12-month period;
2 and

3 “(C) the State plan establishes (with the approval of the Secretary)
4 minimum and maximum payment levels (whether determined prospec-
5 tively or retrospectively on a fee-for-service, capitation, cost, or other
6 basis) with respect to the care and services described in subparagraph
7 (B).

8 “(3) The State will provide to the Secretary annually, in conjunction
9 with reports provided under section 1902(a)(6) and consistent with a data
10 collection plan designed by the Secretary, information on assistance
11 provided under the community care plan under this section and on the plan's
12 impact on the amount and type of medical assistance provided under the
13 State plan with respect to skilled nursing facility and intermediate care fa-
14 cility services.

15 “(c) During the 12-quarter period beginning October 1, 1981, the Secretary
16 may waive the requirement of section 1902(a)(1) as it applies to the administra-
17 tion of community care plans approved under this section.

18 “(d) The Secretary shall annually report to the Congress, in conjunction with
19 any other annual reports required to be made to the Congress with respect to the
20 program under this title, on the plans approved under this section.”

21 (b)(1) Section 1902(a)(10) of such Act is amended—

22 (A) by striking out “and” before “(III)”, and

23 (B) by inserting before the semicolon at the end the following: “, and
24 (IV) the making available of services described in section 1915(b)(2)(B) to
25 individuals pursuant to a State community care plan approved under such
26 section shall not, by reason of this paragraph (10), require the making
27 available of any such services, or the making available of such services of
28 the same amount, duration, and scope, to any other individuals”.

29 (2) Section 1902(a)(14) of such Act is amended—

30 (A) by inserting “or with respect to comprehensive assessments de-
31 scribed in section 1915(b)(1)” in subparagraph (A)(i) after “section
32 1905(a)”; and

33 (B) by inserting “, except that no such charge will be imposed with re-
34 spect to comprehensive assessments described in section 1915(b)(1)” in
35 subparagraph (B)(i) after “individual's income”.

36 (3)(A) Section 1903(i) of such Act is amended—

37 (i) by striking out the period at the end of paragraph (4) and inserting in
38 lieu thereof “; or”, and

39 (ii) by adding after paragraph (4) the following new paragraph:

40 “(5) in the case of a State with a plan approved under section 1915,
41 with respect to any amount expended for skilled nursing facility or inter-

mediate care facility services with respect to an individual unless there has been a comprehensive assessment (described in section 1915(b)(1)(A)) made with respect to the individual, except in such urgent circumstances as the Secretary may provide."

(B) Effective October 1, 1982, paragraph (5) of such section, added by subparagraph (A) of this paragraph, is amended by striking out "in the case of a State with a plan approved under section 1915,".

(c) Section 1903(q)(3) of such Act is amended by inserting before the period at the end the following: ", particularly focusing on providers of services described in section 1915(b)(2)(B)".

(d) Except as provided in subsection (b)(3)(B), the amendments made by this section shall apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on or after October 1, 1981.

ENCOURAGING HMO PARTICIPATION IN STATE MEDICAID PLANS

SEC. 6330. (a) Paragraph (2)(A) of section 1903(m) of the Social Security Act is amended by striking out "and" at the end of clause (i), by striking out the period at the end of clause (ii) and inserting in lieu thereof a semicolon, and by adding at the end the following new clauses:

"(iii) such services are provided for the benefit of individuals eligible for benefits under this title in accordance with a contract between the State and the entity;

"(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, and (II) to services performed or determinations of amounts payable under the contract;

"(v) such contract provides that in the entity's enrollment of individuals who are eligible for benefits under this title and eligible to enroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services; and

"(vi) such contract (I) permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination, and (II) provides for notification of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment."

(2) Paragraph (2)(A)(ii) of such section is amended by striking out "one-half" and inserting in lieu thereof "three-quarters".

97th Congress }
1st Session }

HOUSE OF REPRESENTATIVES

{ REPT. 97-158
{ VOLUME II

OMNIBUS RECONCILIATION ACT OF 1981

REPORT

OF THE

COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 3982

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO
SECTION 3 OF THE FIRST CONCURRENT RESOLUTION ON
THE BUDGET FOR FISCAL YEARS 1982, 1983, AND 1984

together with

SUPPLEMENTAL, ADDITIONAL, AND MINORITY
VIEWS



[R-2]

VOL. II

JUNE 19, 1981.—Committed to the Committee of the Whole House on the
State of the Union and ordered to be printed

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Sec. 6329 Options for the provision of home and community-based care and requirements of preadmission

Under current law, Medicaid provides little or no coverage for long-term care services in the community, while offering full or partial coverage for such care in an institution. The Committee is concerned that even though only approximately 6% of the elderly reside in institutions, more than 40% of Medicaid expenditures went for institutional care this year.

It has been estimated that a quarter of the current nursing home population does not need full-time, residential care. Many elderly, disabled and chronically ill persons live in institutions not for medical reasons, but because of the paucity of health and social services in their communities, and their inability to pay for those services or to have them covered by Medicaid when they do exist.

Assessment procedures required under Medicaid to determine the need for institutional care for the elderly and disabled have not been adequate in preventing avoidable admissions. Most of the reviews occur after admission to the long-term care facility, when it is most difficult to discharge the resident back to the community. In addition, the reviews focus on medical conditions primarily, and not on social and other factors which are often more critical in determining the most suitable placement.

The Subcommittee held several hearings on this issue during the 96th Congress; December 11, 1979 and May 30, June 10 and June 23, 1980. Witnesses representing the National Governors' Association, the Association of State Medicaid Directors, National Conference of State Legislators, along with representatives of all the major aging organizations, submitted testimony. Also presenting their views were organizations representing persons with chronic diseases, developmentally disabled persons,

representatives of the home health industry and the nursing home industry, professional and consumer organizations involved in long-term care, and others. All testified for the need for medicaid coverage of home care.

Last year, a bill was introduced (The Medicaid Community Care Act of 1980) which responded to this issue, and enjoyed the cosponsorship of over 130 House members. Sec. 6329 incorporates much of that bill.

The Committee believes this section goes a long way in addressing the issue of inappropriate institutionalization and the need for community-based services for the elderly and disabled.

Under the provisions of this section, states which elect to have home-based care covered by medicaid would be required to develop a community care plan subject to the approval of the Secretary. Under the plan, states would have to provide for a comprehensive assessment of all persons who are eligible or applying for medicaid coverage for care in a skilled nursing facility (SNF) or an intermediate care facility (ICF; ICF-MR). The assessment must be a direct and personal one, where the person performing the assessment actually sees and interviews the person applying for care.

This assessment should take place soon after application is made, and should be conducted by trained persons, preferably by a multi-disciplinary team of health and social service workers. This assessment must take into account all the factors, including family supports, community ties, and health and financial factors, relating to the need of the individual for long-term care in a SNF or ICF.

To avoid potential conflict of interest, this assessment, with certain exceptions, should not be conducted by persons or agencies who would benefit directly or indirectly from the results of the assessment. This would include persons or entities which have an ownership or controlling interest in, or contract with agencies or facilities which might provide services to persons as a result of the assessment. The Committee recognizes that in some states there are few trained health and social services personnel and facilities equipped to conduct assessments and provide care. To require a division of those functions in such underserved areas could impede the

development of home-based services and ultimately deny medicaid recipients alternatives to institutionalization. Therefore this section provides an exception in such areas.

The Committee has also made provision for exception on this point under other special circumstances that the Secretary may approve. This will allow limited Secretarial discretion in approving, for example, plans submitted by those States which have in place on a statewide or partial-state basis, a demonstration similar to the community care plan described in this section, where assessments currently are done by providers of care. Public entities, such as State or county health departments, also are eligible for the exceptions from this provision.

The purpose of the assessment for which no co-payment may be required of recipients, is to determine whether the recipient needs a level of care comparable to that provided in a SNF or ICF. The individual would be informed in writing of the determination and, if such a level of care is found to be necessary, be informed of all feasible alternatives and given the option of institutional or community-based, noninstitutional care.

The determination of what long-term care options are feasible in a particular instance should be based on the individual's needs, as determined by the comprehensive assessment, and not short-term cost savings. While the Committee anticipates that the provision of community-based care will have a long range and significant impact on the size of states' Medicaid budgets, it does not believe that states should make decisions regarding feasibility of community-based care on the basis of whether or not such arrangements will produce short-term cost savings.

The Committee views the services under this section as a means of furthering established federal policy of deinstitutionalization and promoting access to community-based services, as evidenced by other federal programs, including the Developmental Disabilities Assistance and Bill of Rights Act.

In the event that an individual is aggrieved by the results of the assessment and its recommendation, the Committee expects that states will provide such persons with an opportunity to present additional medical and related evidence at a fair hearing. Since a finding that community-based services are not feasible in a particular case constitutes a denial of services covered under a state's Medicaid plan, the Medicaid statute requires that applicants and beneficiaries be provided with the procedural protections of the Medicaid administrative hearing process.

The Committee intends that with the expansion of services under this section there be no diminution or weakening of quality standards for long-term care services provided both in the community, and in institutions. In the case of services for the mentally retarded and the developmentally disabled, the Committee emphasizes the need for quality standards appropriate and specific to both the large and small ICF-MRs. Furthermore, providers of community services to residents of these facilities should coordinate their services with responsible staff of those facilities, to assure a continuity of care.

For persons determined to be in need of nursing home level of care who choose, instead, to remain in the community, the State would be required to provide for the development of a written plan of care describing the service needs of the individual and prescribing those services. The committee emphasizes that the ultimate choice about institutional placement rests with the patient and appropriate family members.

There is considerable variation among the States with respect to the organization of health and social services with respect to sophistication in dealing with long-term care, and other pertinent factors. Recognizing this, the Committee intends to allow States the greatest possible flexibility in establishing plans with respect to the comprehensive assessments, plans of care development, and the provision of services, with certain exceptions outlined above which are intended to prevent conflict-of-interest. For example, States could develop their plan for providing

community care in a number of ways. A State agency or agencies could conduct the comprehensive assessments, develop the plan of care, and provide the services. Or, the States could contract with private or public agencies to carry out some or all of these functions under proper licensure procedures. However, in order to assure the State Agency of adequate fiscal control, the plan of care required would be initially approved and reviewed periodically by the State. This function could also be carried out by contract.

The Committee intends for a wide variety of non-institutional services to be covered under this section. Often such services can be provided most efficiently and effectively by professionals, other than physicians, such as social workers and nurses, qualified mental retardation professionals, and by non-professionals

such as nurse's aides, homemakers, and personal care attendants. Under the plan of care, the level of personnel most appropriate for each service should be specified, and adequate and appropriate reimbursement should be provided.

The services authorized in this section include nursing, home health aide, personal care, medical supplies and equipment, physical and occupational therapy, and speech pathology and audiology. These may now be provided under Title XIX, and are defined in the Medicaid manual. Other services which the Committee intends to have covered are homemaker and adult day care, both defined in Title XX of the Social Security Act.

The Committee wishes to emphasize that adult day care encompasses both health and social services needed to insure the optimal functioning of the client, as well as habilitation services suitable for the care of the mentally retarded and the developmentally disabled.

Respite care is seen by the Committee as essential if families are to be supported in their efforts to care for vulnerable and dependent persons at home. Respite care services are those services given to an individual unable to care for him/herself on a full time basis, which are provided on a short-term basis to such individual because of the absence of or need for relief for those persons normally providing such care. Services can be offered in the home of an individual, or in an approved facility such as a hospital, a nursing home, a foster home, or a community residential facility.

In order for elderly and disabled persons to benefit from the services covered in this section, the Committee recognizes the need for a case management system, under which responsibility for locating, coordinating and monitoring long term care services in behalf of a recipient rests with a defined person or agency. It is the Committee's intent that the case manager be responsible for locating available sources of help from within the family and the community, so that

the burden of care will not be exclusively borne by formal health and social agencies. The "informal network" of friends, relatives, churches, clubs, etc., should be used wherever feasible to strengthen the elderly or disabled person's ties with his own community.

Because the needs of recipients of long-term care services are varied and complex, the Committee intends for the States to have flexibility in deciding which community-based services are most relevant. Therefore, under this section, States would be allowed, with Secretarial approval, to provide additional services, not listed here, which would aid in the goal of helping vulnerable elderly and handicapped persons remain in the community. This provision does not affect the States' authority to impose limitations on amount, duration and scope of services provided to other Title XIX eligibles not included in the community care plan.

The Committee recognizes that in order to provide a mix of appropriate and cost effective services tailored to the needs of individual recipients, it would be unwise to set a limit on the specific amount and type of services available to each client. But to insure fiscal responsibility, States may establish an annual per capita ceiling on the cost of the total amount of services each client may receive. This limit need not be less than the amount required to maintain the applicant in an institution for a 12-month period. Since service costs for a client are often higher during the initial period of care (for example, when a patient is discharged from a hospital after an acute illness) than they are when the client's condition is more stable, the State will be allowed to average the per-person cost of care over a 12-month period to arrive at the total. The experience of the New York State long-term home care program has found this an effective fiscal device.

Since the cost and availability of community-based care are of concern to the Committee and to the States, this section requires States

to establish minimum and maximum reimbursement rates. The Committee intends that the establishment of minimum reimbursement levels will assure adequate payment to service providers so as to encourage them to participate in the program. Maximum rates assure that costs can be controlled while providers deliver reasonably priced and adequate care. The Committee wishes to encourage innovation by States to determine these reimbursement levels and therefore allows States to examine a wide variety of methods, such as capitation, fee for service, or others, and to make use of prospective or retrospective reimbursement methods in developing a plan for payments. The Committee anticipates that this flexibility will enable States to achieve optimal cost efficiency and simplification of program administration.

The Committee requires States to submit data to the Secretary under a uniform data collection plan. This is needed to obtain accurate information on the kinds of services States have made available under this program, and to assess the relationship between the provision of community-based services and the utilization of hospitals and long-term care facilities by program recipients, and to compare their costs. The General Accounting Office, in its report "Entering a Nursing Home: Costly Implications for Medicaid and the Elderly", strongly recommended this measure. In this connection, the Committee would recommend that the Secretary review data collection systems currently being used in long term care programs in different States ("channeling" contracts now being administered in HHS utilize a consistent system, for example) to determine the possibility for this program to use a data collection system already developed.

State reports to the Secretary must include all services provided under the plan for community care, as well as a detailed compilation of total expenditures, under all federal programs, for institutional and non-institutional, direct and indirect, services in support of long term care.

The development and implementation of a State community care plan is a time-consuming and complex process, often requiring the coordination of several agencies, and sometimes State legislative action. Many areas of the country do not have community-based services readily available, or sufficiently developed to take care of the needs of large numbers of people. Therefore, the section allows States to apply to the Secretary for a one time waiver of the State-wideness provision, for a three-year period. This will enable a State to initiate an assessment and delivery system in one part of that State, and there test out methods for provision of service, for reimbursement, etc., which over a three-year period can be applied to the State as a whole.

It is the intent of this section that no Medicaid eligible person, in a State which adopts this option, shall enter a SNF or an ICF, or ICF-MR, who has not had an assessment which indicated such placement was appropriate. The Secretary is expected to define those urgent circumstances under which this requirement may be waived since elderly and handicapped persons often need immediate or emergency placement. This provision, for mandatory assessments before a Medicaid eligible person may be placed in a long-term care facility, takes effect in all States on or after October 1, 1982.

All other provisions of this section are voluntary, and become effective October 1, 1981. The Committee intends for States which are ready and willing to prepare a plan for assessment and provision of community-based services be able to do so at the earliest possible time.

The Committee bill provides that State expenditures for both institutional services and non-institutional services, included under this section, shall not exceed the amount which a State would otherwise spend on institutional and noninstitutional long-term care services ordinarily covered under its Medicaid plan.

The Secretary may enter into an agreement with a State regarding the amount of expenditures that will be recognized, for purposes of payment to the State for long-term care services under its State plan.

In reaching an agreement on recognized levels of expenditures for long-term care services, a State and the Secretary must demonstrate that their agreement includes a determination of the institutional and noninstitutional long-term care needs of the State's Medicaid population, and the cost of promptly providing adequate levels of services to program beneficiaries. The agreement must not establish arbitrary expenditure ceilings that prevent access by program beneficiaries to essential long-term care services.

The Committee emphasizes that assurances regarding the level of expenditures for long term care must reflect and include the total expenditures under all Federal programs for institutional and noninstitutional long term care services.

97TH CONGRESS }
1st Session }

SENATE

{ REPORT
No. 97-139

OMNIBUS RECONCILIATION ACT OF 1981

REPORT

OF THE

COMMITTEE ON THE BUDGET

UNITED STATES SENATE

TO ACCOMPANY

S. 1377

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO
TITLE III OF THE FIRST CONCURRENT RESOLUTION ON
THE BUDGET FOR FISCAL YEAR 1982 (H. CON. RES. 115,
NINETY-SEVENTH CONGRESS)



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The vaccination service would be available from wherever the SSI recipient normally receives services under the medicaid program or, if not eligible for medicaid, through State or local health department clinics. The Federal Government would provide States with 100-percent matching through the medicaid program, up to a maximum of \$10 per vaccination. In addition, 100-percent Federal matching would be available on a ongoing basis, for the reasonable cost (up to \$10 per vaccination) for providing the service to SSI and medicaid recipients, age 65 and older.

The committee intends that funds made available under this provision would be in addition to those to which a State was otherwise entitled under medicaid and would not be counted toward the limitation on Federal expenditures (i.e., the medicaid cap) provided for under Section 21 of the bill.

The committee expects that the majority of other aged individuals not receiving assistance under this provision will be able to budget for the relatively small charge of a pneumococcal vaccination.

Estimated cost.—

Fiscal year:	Millions
1981.....	-----
1982.....	\$8
1983.....	1
1984.....	1

NONMEDICAL SERVICES FOR CERTAIN INDIVIDUALS

(Section 730 of the Bill)

Present law.—Federal matching under medicaid is only available for services which are primarily medical in nature. Certain associated services are not eligible for Federal matching payments. However, these services while not strictly medical in nature may in fact contribute to improved health, and could potentially postpone or prevent institutionalization. To the extent that institutionalization is deferred or avoided, certain cost savings may result.

Committee amendment.—The bill permits the Secretary to waive the current definition of covered medicaid services to include certain nonmedical support services, other than room and board, which are provided pursuant to a plan of care to an individual otherwise at risk of being institutionalized and who would, in the absence of such services be institutionalized. Such services could include case management, supervised living, home services and nonmedical rehabilitation services approved by the Secretary. A waiver cannot be granted unless the State provides assurances satisfactory to the Secretary that necessary safeguards have been taken to protect the health and welfare of any of the recipients of such services. The committee expects that States which have been granted a waiver will examine innovative and cost-efficient means of rendering services to this population group.

Estimated Savings

(Assumed in medicaid cap)

except that if the Secretary determines that [the hospital had (during the immediately preceding calendar year) an average daily occupancy rate of 80 percent or more], there is not an excess of hospital beds in such hospital or in the area of such hospital which could be converted for use in providing the required skilled nursing facility services or intermediate care facility services (as the case may be), such payment [shall] may be made (during such period) on the same basis as otherwise used under the State's plan for payments for providing inpatient hospital services.

*(4) For the purpose of determining the occupancy rate with respect to hospitals under paragraph (2)—

(A) public hospitals under common ownership may elect (with the approval of the Secretary) to be treated as a single hospital, and

(B) beginning two years after the date this subsection is first applied with respect to a hospital, the Secretary, to the extent feasible, shall not treat as an inpatient an individual with respect to whom payment is made to the hospital only because of this subsection or section 1861(v)(1)(G)]

X (k)(1) The Secretary may waive any requirements of this title with respect to provision of or payment for medical care in order to permit the State agency to share, by means of providing additional services, with any recipient of medical assistance under the State plan, any cost savings which may result from use by such recipient of medical care which is more cost-effective than medical care generally provided or paid for under such plan. A waiver shall not be provided under this paragraph unless the State provides assurances satisfactory to the Secretary that the granting of such waiver would not be inconsistent with the purposes of this title.

(2) The Secretary may by waiver provide that a State plan approved under this part may include as 'medical assistance' under such plan personal care services and any other services (other than room and board) approved by the Secretary which are provided pursuant to a plan of care to an individual who, but for such services, may require institutionalization in a medical institution in which the cost of his care could be reimbursed under the State plan. A waiver shall not be granted under this paragraph unless the State provides assurances satisfactory to the Secretary that necessary safeguards have been taken to protect the health and welfare of any recipients of such services.

(l)(1) The Secretary may by waiver provide that a State plan approved under this part may include as "medical assistance" under such plan—

(A) case management;

(B) supervised living;

(C) home services;

(D) rehabilitation; and

(E) any other nonmedical services (other than room and board) approved by the Secretary,

which are provided pursuant to a plan of care to an individual who is mentally ill, mentally retarded, or otherwise at risk of being institu-

tionalized, if such services were not provided, in a medical institution in which the cost of his care could be reimbursed under the State plan.

(2) A waiver shall not be granted under paragraph (1) unless the State provides assurances satisfactory to the Secretary that necessary safeguards have been taken to protect the health and welfare of any recipients of such services.

(m) Individuals specified in section 1902(a)(10)(A) shall include—

(1) any child on whose behalf foster care maintenance payments are being made under any program administered by or administered under the supervision of the State—

(A) who would meet the requirements of section 406(a) or of section 407 but for his removal from the home of a relative specified in section 406(a);

(B) whose removal from the home was the result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child; and

(C) (i) who received aid under the State plan approved under section 402 in or for the month in which court proceedings leading to the removal of the child from the home were initiated,

(ii) who would have received such aid in or for such month if application had been made therefor, or

(iii) who had been living with a relative specified in section 406(a) within six months prior to the month in which such proceedings were initiated, and would have received such aid in or for such month if in such month he had been living with such a relative and application therefor had been made; and

(2) any child on whose behalf adoption assistance payments are being made under any program administered by or administered under the supervision of the State—

(A) who but for adoption would meet the requirements specified in paragraph (1), or

(B) who but for adoption would meet the requirements of title XVI with respect to eligibility for supplemental security income benefits.

Payment to States

Sec. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g), (h), and (j) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligi-

Mr. WAXMAN. Before introducing our first witness, I would like to recognize the members of our subcommittee who are here, and call upon them for an opening statement.

We are pleased to welcome all those who are going to testify with us. We want to hear your views. One of the purposes of Congress is to pass laws. But another very important purpose is to try to see how our laws are working, whether they are being enforced, and whether the intent of Congress is being followed. That is the purpose of this oversight hearing.

I would like to recognize Congressman Tauke at this time. We are very fortunate to have him as a member of this subcommittee.

Mr. TAUKE. Thank you. I commend you for holding these hearings, Mr. Chairman. You have provided those of us on the subcommittee an opportunity to review the progress, current status, and the future potential of the program enacted in 1981 in response to the growing need and desire for alternatives to institutionalization for the handicapped, disabled and the medically fragile, high-technology-assisted child. By enacting this program, we, who are committed to the provision of alternatives to institutionalization, sought to promote the development and utilization of home and community-based services by the States.

Today we will look and see if the intent of Congress is being realized, if there are problems hampering the willingness or the ability of the States to participate in the program, and if we, as legislators and Federal and State health care policymakers, need to take further action to perfect this program or to develop other initiatives in the provision of alternatives to institutionalization.

These are questions of vital importance to our Nation's elderly, whose lives are shadowed by the fear of spending the remaining months or years of life in an institution. They are questions of vital importance to our Nation's physically and mentally handicapped, who, with assistance, can lead more independent lives and know the sense of dignity and self-worth which comes from independence and the ability to take responsibility for one's needs. They are questions of vital importance to the medically fragile, technology-assisted child facing a lifetime of institutionalization.

Under this waiver program, these children may be able to grow up in the midst of their families. Their progress under home care is often remarkable, as I believe you will agree when you have a chance to meet Katie Beckett, the first waiver child.

It is important to remember this morning that we are focusing on just one program designed to meet some of this need and desire for alternatives to institutional care. The Medicaid Program cannot and should not be asked to bear the full weight of this need.

There is a role here too for private insurers. There is a compelling need for the development of a partnership among Federal and State health policymakers and private insurers to explore alternatives for meeting the need for home and community-based services. Federal and State income tax systems offer yet another alternative for promoting home and community-based services through the provision of tax credits to help family caretakers offset the cost of the care they provide.

It is important to look beneath the controversy which may arise over regulations recently issued for the home and community-based program to determine what may be motivating these regulations.

Frankly, I don't think it is a desire on the part of this administration to hamstring the program. After all, it was the President, in calling attention to Katie Beckett's need for an alternative to institutionalization, who gave impetus to the home and community-based program. What may lie beneath the controversy over the current regulations and what, in fact, we may all be debating this morning without realizing it is the woodwork question. The question essentially is this: While we may be able to demonstrate the cost neutrality or cost effectiveness of providing home and community-based care as opposed to institutional care on a case-by-case basis, will the sheer numbers of potentially eligible persons currently and in the future negate these savings and greatly increase costs for Federal and State programs and private insurers?

In exploring this question, Congressman Waxman and I have found our health care technology and ability to provide home care services have greatly outdistanced the data we have available to answer this question and the related questions of what is now being done in the private sector, either by insurers or individuals, to provide home and community-based services.

I am very gratified by the chairman's interest in this issue and by his joining with me to approach the Office of Technology to study it and begin to build the data base we need for informed health care policy decisions. I am also encouraged by the interest of the Office of Technology and Assessment in this study.

The Home and Community-Based Waiver Program is an important first step toward the provision of alternatives to institutionalization for the majority of our population. Monitoring the progress and working and seeking to resolve the problems of this program are important not only in insuring this first step is itself a strong one. Examining this one program is also important to stimulating interest in the underlying questions which must be addressed before we can expect to see more widespread interest in home and community-based services.

I, therefore, would encourage you, Mr. Chairman, to make this the first in a series of hearings on alternatives for the provision of home and community-based services. Thank you.

Mr. WAXMAN. Thank you. Mr. Wyden.

Mr. WYDEN. Thank you very much. I, too, appreciate your important leadership in on issue I think is critical for the country's senior citizens and others in terms of long-term care. As Chairman Waxman has said, the 1981 Omnibus Budget Act gave the States the ability to offer Medicaid coverage for a broad range of community-based health care services. The problem is: is what Congress gave the Office of Management and Budget, the Health Care Financing Administration taketh away.

The administration dragged their feet for 4 years before issuing final regulations for the waiver program authorized in the 1981 Budget Act. In the interim, a number of States, like my own, struggled in a massive, sticky bureaucratic swamp. Waivers were granted or renewed only after months of meetings, mountains of paper and a morass of aggravation and anxiety for State officials and pa-

tients alike. But the worst was yet to come. When the regulations finally were issued in March of this year, they put a virtual killer hold on the program. The restrictions, the assurances, the projections, the paperwork, the huge number of hurdles that States need to jump through, remove, in my view, virtually every single important incentive a State might have to care for older people and the disabled in their homes and in the community.

Where we are today? The efforts to develop cost efficient alternatives to nursing home care are in a bureaucratic limbo. But I think nobody in this room would debate the proposition that these alternatives are needed.

Now, in an effort to retain the flexibility so important in assuring that States can move forward with providing home and community-based care, Senator Bill Bradley and I have introduced legislation which would eliminate the waiver approval process altogether. Under the Bradley-Wyden legislation, a State would still have to submit documentation that would prove that a waiver program would not increase Medicaid costs. But under our bill, the States would no longer be at the whim of the Health Care Financing Administration and the Office of Management and Budget's regulation writers.

One last point, Mr. Chairman. My State recently conducted a survey of State Medicaid and aging directors as to whether or not they felt that the current waiver arrangement was satisfactory. The response was an overwhelming no. Ninety-four percent, 32 of the States expressed dissatisfaction with the current program.

In this survey that, the approach Senator Bradley and I take in our legislation, that makes home and community-based care an option States can select first choice among the solutions. So, Mr. Chairman, I think we have got a lot of work to do.

As I said earlier, what the Congress giveth, the Health Care Financing Administration has tried to taketh away. I think that is an intolerable situation, and we have to turn it around.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. Nielson, do you have a comment?

Mr. NIELSON. No.

Mr. WAXMAN. Mr. Walgren.

Mr. WALGREN. Thank you, Mr. Chairman.

It is my privilege today to introduce to the committee and to the Congress a constituent of mine, Ms. Merilee Trapp, who is with us today from one of the institutions in our district, and I think that the fact that a number of us on this committee have individuals such as Katie Beckett and Ms. Trapp is an indication of how widespread the individual people who find themselves facing this kind of difficulty are across the country.

To me, this hearing and our ability to bring the attention of the Congress and get a proper response from the administration is a real test of whether our system works with sensitivity to individuals. If the Congress cannot pass this kind of legislation and have it given life by any administration when the proper attention is brought to what is happening under it, then we are all at sea, and would have to think more than twice about whether our Government can provide us effective remedies for the circumstances that we find ourselves in.

In this particular instance of Ms. Trapp, she faces, as I understand it, the test that was put to the waiver was whether or not the cost of her care was less expensive than the average cost of care to individuals in the institution in which she finds the only source of the care she needs.

Now, the difficulty is that the average people who find themselves in that institution are somewhere over the age of 80 and 85 years. Ms. Trapp is 37. And the fact of it is that the average person in that institution only lasts 207 days, and so for Ms. Trapp, who is faced with living in that institution 365 days a year, she had to show to HCFA that her cost would be less than 207 days of care.

Now that is the kind of pure, unadulterated—words fail me—that come from the combination of—

Mr. WAXMAN. This is going to be in the Congressional Record, be careful.

Mr. WALGREN. This is the kind of thing we are up against. We really hope we will receive the proper attention from the administration and the kind of instinctive recognition of wrong that was started in Ms. Beckett's case and now should be extended to individuals across the country who find themselves in similar circumstances.

Mr. Chairman, I really appreciate your holding this hearing. I think nothing could be more important, and look forward to working on the problem with you.

Mr. WAXMAN. Thank you, Mr. Walgren.

Mr. SIKORSKI. I have no formal statement. I did want to commend you, for the record, for your earnestness and diligence in pursuing this matter which has been close to all of our hearts for many years, and welcome the panel here for their instructions. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much.

Our first witness was supposed to have been Congressman, former Senator, Claude Pepper, who was a coauthor of the legislation we later put into the bill in 1981 that provided for the 2176 waiver statute. Unfortunately, Chairman Pepper is not feeling well and couldn't be with us this morning. However, we would like to make his statement part of the record at this point in our proceedings.

I want to share with the members the closing remarks in Mr. Pepper's statement. He said:

No spouse should be forced by economic circumstances or lack of community alternatives to send their loved one to a nursing home. No adult child should be forced to institutionalize a parent simply because the child can no longer take care of the parent at home without help. No parent should be forced to institutionalize a chronically ill or retarded child simply because Medicaid will pay for needed services only in an institution.

I think this says, as eloquently as can be said, what this program is supposed to be all about.

[Mr. Pepper's prepared statement follows:]

NEWS

Select Committee on Aging

U.S. House of Representatives

CLAUDE PEPPER, Chairman
Subcommittee on Health and Long-Term Care
300 New Jersey Ave., S.E., Room 715
Washington, D.C. 20515
202/226-3381



FOR IMMEDIATE RELEASE
Tuesday, June 25, 1985

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STATEMENT BY CONGRESSMAN CLAUDE PEPPER
CHAIRMAN, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
ON
"THE MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVERS"
BY THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

MR. CHAIRMAN, IT GIVES ME GREAT PLEASURE TO COME BEFORE THIS DISTINGUISHED SUBCOMMITTEE TO COMMENT ON THE MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER -- WHICH IS SOMETIMES REFERRED TO AS THE "2176" WAIVER. I WANT TO COMMEND MY DEAR FRIEND AND RESPECTED COLLEAGUE, HENRY WAXMAN, WHO JOINED ME 5 YEARS AGO IN AUTHORIZING THIS WAIVER, FOR CONVENING TODAY'S INQUIRY INTO THE PROGRESS AND PROBLEMS EXPERIENCED BY THE STATES SINCE THE WAIVERS HAVE BECOME AVAILABLE.

IT SADDENS ME TO SAY, MR. CHAIRMAN, THAT WITH THE EXCEPTION OF THE WAIVER PROGRAM, LONG-TERM CARE FOR ALL AMERICANS STANDS TODAY AS THE MOST, TROUBLED, AND TROUBLESOME COMPONENT OF OUR ENTIRE HEALTH CARE SYSTEM.

WITH THE ENACTMENT OF THE MEDICARE AND MEDICAID PROGRAMS IN 1965, WE MADE A SOLEMN COMMITMENT: ACCESS TO QUALITY HEALTH CARE SHALL NOT BE LIMITED BY AGE OR INCOME. WE HAVE ACHIEVED A GREAT DEAL. THESE VITAL PROGRAMS HAVE BEEN INSTRUMENTAL IN IMPROVING THE HEALTH AND WELL BEING OF MILLIONS OF AMERICANS.

SADLY, HOWEVER, FOR THOSE REQUIRING LONG-TERM CARE -- OFTEN THE MOST VULNERABLE AND NEEDY OF OUR SOCIETY -- WE OFFER LITTLE MORE THAN A BROKEN PROMISE. FOR THE MOST PART, FEDERAL AND PRIVATE INSURANCE COMPANIES ARE DESIGNED TO FINANCE HEALTH CARE TREATMENTS ONLY WHEN ILLNESS IS ASSOCIATED WITH PERIODS OF HOSPITALIZATION.

OUR HEALTH CARE SYSTEM VIRTUALLY RULES OUT FINANCIAL ASSISTANCE FOR CARE THAT MAY PREVENT OR POSTPONE COSTLY AND PREMATURE INSTITUTIONALIZATION. WHILE WE SPEND OVER \$30 BILLION FOR INSTITUTIONAL CARE -- WE SPEND ONLY \$4 BILLION FOR HOME HEALTH CARE. NEARLY 40 PERCENT OF MEDICAID MONIES GO TO NURSING HOME CARE; LESS THAN 5 PERCENT GOES TOWARDS NON-INSTITUTIONAL CARE. OUTSIDE OF THE MEDICAID PROGRAM, WHICH FAVORS INSTITUTIONALIZATION, LITTLE IS AVAILABLE. ALMOST ALL THE REST IS PAID OUT OF THE POCKETS OF THE FAMILIES OF THOSE AFFLICTED BY LONG-TERM ILLNESS.

YOU CAN IMAGINE THE SHOCK OF OUR SUBCOMMITTEE WHEN THE DAUGHTER OF AN ALZHEIMER'S PATIENT TESTIFIED, "MY DOCTORS TOLD ME THAT THE ONLY WAY TO GET ASSURED FINANCIAL ASSISTANCE FOR MY MOTHER WOULD BE TO BREAK HER ARM AND HAVE HER PUT IN THE HOSPITAL AND WHEN HER ARM HEALED, BREAK IT AGAIN AND KEEP BREAKING IT IF YOU WANT TO ASSURE FINANCIAL ASSISTANCE."

OF COURSE, HER DOCTOR WAS NOT SERIOUS ABOUT GOING TO SUCH LENGTHS, BUT THE POINT WAS UNFORTUNATELY WELL MADE, BECAUSE THE ESSENTIAL ELEMENTS OF TREATING ALZHEIMER'S PATIENTS CAN BE PROVIDED IN THE HOME AND DO NOT REQUIRE HOSPITALIZATION OR INSTITUTIONALIZATION.

ALTHOUGH WE LIVE IN A RICH NATION, THERE ARE TERRIBLE GAPS IN OUR HEALTH AND SOCIAL PROGRAMS WHICH UNDERScore THIS SAD TRUTH: THERE IS NO MEANINGFUL LONG-TERM CARE POLICY TODAY IN THE UNITED STATES. THERE ARE HUNDREDS OF THOUSANDS OF AMERICANS WHO REMAIN THE VICTIMS OF A HEALTH CARE DELIVERY SYSTEM NOT GEARED TO PROVIDING SERVICES IN THE LEAST RESTRICTIVE ENVIRONMENT, THE HOME.

MR. CHAIRMAN, IN AN EFFORT TO END THE GREAT INSTITUTIONAL BIAS IN THE MEDICAID PROGRAM, YOU AND I SPONSORED LEGISLATION CREATING THE 2176 WAIVER PROGRAM. WE THOUGHT THAT THIS PROGRAM WOULD HOLD GREAT PROMISE FOR STATES TO BE ABLE TO OFFER A RANGE OF HOME AND COMMUNITY BASED LONG-TERM CARE SERVICES FOR THOSE WHO OTHERWISE WOULD HAVE REQUIRED NURSING HOME CARE.

THE STATES HAVE RESPONDED MOST COMMENDABLY. ABOUT 90 PROGRAMS OFFERING HOMEMAKER AND HOME HEALTH SERVICES, ADULT DAY CARE, RESPITE CARE AND OTHER COMMUNITY SERVICES TO NEARLY 100,000 ELDERLY AND DISABLED AMERICANS ARE NOW IN PLACE. THE DEPARTMENT OF HEALTH AND HUMAN SERVICES REPORTS THAT LAST YEAR THESE PROGRAMS RESULTED IN COST SAVINGS OF OVER \$80 MILLION. IN MY OWN STATE OF FLORIDA, I WAS TOLD THAT IN 1984-1985, THE STATE PAID ABOUT \$3,500 PER AGING MEDICAID CLIENT UNDER THE WAIVER, AS COMPARED WITH \$10,600 PER AGING MEDICAID CLIENT IN A NURSING HOME.

I SHOULD MENTION AT THIS POINT THAT ALTHOUGH THE WAIVER PROGRAM HAS HAD THE UNINTENDED EFFECT OF SAVING MONEY -- THIS WAS NOT A REQUIREMENT OF THE PROGRAM. THE WAIVER PROGRAM, AS ENACTED, WAS INTENDED AS A WAY TO LEARN ABOUT THE COST OF LONG-TERM CARE IN THE COMMUNITY AND TO LEARN THE APPROPRIATE WAYS TO MANAGE CHRONICALLY ILL PATIENTS IN THE HOME -- AS LONG AS IT DID NOT COST MORE THAN INSTITUTIONAL CARE.

I NOW UNDERSTAND THAT REGULATIONS RECENTLY ISSUED ON MARCH 13 BY THE ADMINISTRATION IGNORE THIS CONGRESSIONAL INTENT, AND TRY TO CONVERT THE WAIVER PROGRAM FROM A BUDGET-NEUTRAL DEVICE INTO A TACTIC FOR CUTTING MEDICAID SPENDING. THIS IS DISTRESSING NEWS TO THE STATES AND CONTRARY TO LEGISLATIVE INTENT.

WE ALL AGREE THAT THE COSTS OF HEALTH CARE MUST BE CONTROLLED AND MEASURES DESIGNED TO ACCOMPLISH THIS OBJECTIVE WILL BE GIVEN CONSIDERATION. HOWEVER, TO SINGLE OUT THE ONE INNOVATIVE NATIONAL PROGRAM PROVIDING AN ALTERNATIVE TO INSTITUTIONALIZATION AND ASKING IT ALONE TO SAVE MEDICAID DOLLARS IS A PERFECT EXAMPLE OF AN ADMINISTRATION GONE AWRY.

THE GOAL OF THE WAIVER PROGRAM IS TO OFFER AMERICANS IN NEED OF LONG-TERM CARE A CHOICE OF RECEIVING THOSE SERVICES IN THEIR HOMES OR IN A NURSING HOME -- THIS IS A CHOICE THE CONGRESS INTENDED TO FOSTER, NOT INFLUENCE, ON THE BASIS OF COST.

FAMILIES SHOULD BE HELPED IN THEIR EFFORTS TO MAINTAIN THEIR LOVED ONES IN THE HOME OR IN THE COMMUNITY -- NOT FORCED TO JUSTIFY THE COST SAVINGS ASSOCIATED WITH SUCH MAINTENANCE.

NO SPOUSE SHOULD BE FORCED BY ECONOMIC CIRCUMSTANCES OR THE LACK OF COMMUNITY ALTERNATIVES TO SEND THEIR LOVED ONE TO A NURSING HOME. NO ADULT CHILD SHOULD BE FORCED TO INSTITUTIONALIZE A PARENT SIMPLY BECAUSE THE CHILD CAN NO LONGER TAKE CARE OF THE PARENT AT HOME WITHOUT HELP. NO PARENT SHOULD BE FORCED TO INSTITUTIONALIZE A CHRONICALLY ILL OR RETARDED CHILD SIMPLY BECAUSE MEDICAID WILL PAY FOR NEEDED SERVICES ONLY IN AN INSTITUTION.

IN AMERICA, WE CAN AND MUST DO BETTER.

MR. CHAIRMAN, I AM HOPEFUL THAT TODAY'S HEARING WILL EXPLORE HOW WE CAN DO BETTER IN THE AREA OF LONG-TERM CARE, HOW WE CAN HELP, NOT HINDER, THE STATES' DEVELOP A COMPREHENSIVE CONTINUUM OF CARE, A POLICY CAPABLE OF ADDRESSING THE PREVENTATIVE, ACUTE AND CHRONIC HEALTH CARE NEEDS THAT OUR NATION'S CITIZENS' SO DESPERATELY DESERVE.

THANK YOU.

Mr. WAXMAN. Our first group of witnesses is composed of individuals receiving home or community-based care services or who are trapped in institutions because waivers were disapproved. We are delighted to have Katie Beckett and her parents with us. They have come all the way from Cedar Rapids, IA. Katie is living proof that when government re-examines its eligibility policies, chronically ill children who are now in institutions, their families and government can be better off when they are at home.

Beulah Kines is one of the 35,000 aged people who have received services under the 2176 waiver. Thanks to the waiver, she lives at home in Manassas, VA, with her daughter, Ada Freeman.

Mr. John Randolph is one of about 17,000 developmentally disabled or mentally retarded individuals who are receiving services under a 2176 waiver. The services he receives under the waiver allowed him to return to the community after more than 30 years of institutionalization. We are pleased to have you with us.

And our last witness is Ms. Merilee Trapp, a 37-year-old nursing home resident from Pittsburgh. She has lived in a nursing home since she was 22. Had HCFA approved an application for a 2176 waiver for her and others, Ms. Trapp would be living in the community today. We are pleased to have you with us.

We are delighted you are all here. Don't be intimidated by the fact this is such a formal setting. We want to learn from you what your experiences are, what we can do to try to make things better. As you can tell, we have, I think, a unanimous view that we want to do what is right. We have problems that we must overcome. We are trying to be sure that when we pass laws they are carried out as we intended.

Some of you have brought written statements, and if you have a written statement, we are going to put that in the record. What we

would like to ask you to do is rather than read the statement, try to summarize it, take around 5 minutes, and in that 5-minute period tell us what you think is the most important for us to know. And, of course, your written statements will also be in the record, and we will be able to review them there.

Why don't we start with Ms. Beckett.

STATEMENTS OF KATIE BECKETT, ACCOMPANIED BY JULIE BECKETT, CEDAR RAPIDS, IA; BEULAH KINES, ACCOMPANIED BY ADA FREEMAN, MANASSAS, VA; JOHN RANDOLPH, ASSOCIATION FOR RETARDED CITIZENS OF NEW JERSEY; AND MERILEE TRAPP, KANE-ROSS REGIONAL CENTER, PITTSBURGH, PA

Ms. JULIE BECKETT. Thank you. I have a longer statement which I will provide to the committee at a later date. I would like to read my statement, however.

There are so many things to discuss when talking about long-term care. I often wonder where to begin, but of course I have to begin with Katie, for she is the reason I am here at all.

Katie's history of being a long-term patient started 7 years ago after a bout with viral encephalitis which left her comatose, totally paralyzed and progressed her to become ventilator dependent. It seems hard to believe it has been 7 years, but when I watched her last September put on her uniform and gather up her school things, I couldn't believe the day had finally come for first grade. For here was a child that a little over 2 years before was strapped in the confines of the pediatric intensive care unit in St. Luke's Hospital, limiting her exposure to other children, to a loving family, to a loving community.

We had reached a point in which Katie's life had become stagnant. There was nothing more for them to do but maintain Katie's care at its current level. The nurses and therapist had taught Mark and I all about taking care of Katie's needs, and it was proposed Katie should go home, ventilator and all. It was a beautiful day, thinking Katie was finally coming home after 3 years of running to the hospital three and four times a day. You don't have much of a family life in an institution, even with one as caring as St. Luke's. But shortly after the joy of thinking about having Katie home, reality set in and dashed our hopes for a "normal" family life.

Money, "the almighty dollar," was going to keep us away from our little girl. Katie had incurred such expenses in her long struggle for life, far beyond what our insurance would pay, and had been placed on the Medicaid roles 7 months prior to her discharge. Medicaid rules had been allowed to apply to Katie because she was an individual and not living under our income. When Katie left the institution, her status would again come under our dependency, and we earned too much money to allow Medicaid to help with further health care expenses, even though we could never earn enough to pay for her in-house and in-home hospital costs. We were caught in the typical "catch 22."

We went through the normal channels to try and get an "exception to policy" from the Department of Health and Human Services. We had to review the brushes with death that had occurred

throughout Katie's life. We gathered statistics to show the cost effectiveness in home health care. We did everything we could to convince them that this was going to be so much better for Katie and her family if they could allow her to come home on Medicaid status.

After a very frustrating spring, summer and fall, we received a rejection to our "exception of policy" plea. But we had one person in our corner who had taken the time to listen to Mark and I and to meet Katie. Congressman Tauke had supported the idea of filing for an "exception of policy" and had even gone so far as to have a staff person work with Health and Human Services to gather statistics to show the cost effectiveness.

In late October, it was Tom's office that had received the rejection first. The Congressman then took matters into his own hands by going directly to the Vice President who was heading the Regulatory Reform Commission. Here was a perfect example of where Government failed the common man. The rest is history. The President learned from the Vice President and in a news conference on November 10, 1981, used Katie as an example of how "hidebound regulation" forced Government to be inhuman.

I am very proud to say that since then many persons have also been allowed to receive a waiver to allow them to leave institutions and thrive in the environment of a caring, loving home. What we have seen from this is the prognosis improves dramatically. With Katie alone, one area affected, her speech, has improved so much so that she no longer needs sign language and can be mainstreamed in a first grade classroom where other children can learn about life of a "disabled" person.

Katie has been set as an example for home health care. She has improved so much so that the ventilator which was needed 16 hours a day when she first came home is now only used approximately 7 or 8 hours a day. We don't refer to her as ventilator dependent, but ventilator assisted.

She still needs a daily regimen of activity to keep her status quo and Mark and I perform that as part of our daily routine. It is not without worry and strain, but it is all worthwhile, and we would not and could not go back to life before home health care. Everyone in our community has been affected by Katie's progress. Everyone takes pride in what "we" have all done for her.

When Katie first left the hospital, all contacts had been made with speech therapist, physical therapist, occupational therapist, vendors, suppliers, all to meet the needs Katie had. Over the years these needs have had to be revised, but they are still in actuality. Her care plan has been flexible enough for growth and because of that she has succeeded to become the active participant in our society, not a burden to our society.

What about other cases? Well, without the coordination of services, families cannot take on the added needs of technically-assisted children at home. We are very lucky in Iowa to have many services already in place, but even these services need to be coordinated and expanded to provide a larger opportunity for home and com-

munity-based care. As Iowans, we are seeking to provide this expanded network of home- and community-based services through our State agencies, revealing the commitment our State has made and is willing to make to the provision of alternatives to institutionalization.

In other States, however, few services are available, and that is what makes the continuation and the strengthening of the Home- and Community-Based Waiver Program essential to meet the needs of this "new generation."

Has the waiver been effective? As I speak around the country, a resounding yes comes to the fore. But is the waiver program enough?

Our society has changed dramatically and will change more. We must prepare for these changes.

You have already taken steps to do this through the Medicaid waivers deemed necessary by your committee. A substantial number of children and their families have been served, and, yes, they are doing well. But there are still others who are not being served or who are being served inadequately.

The individual Katie Beckett waivers were an important part of helping these families. On a case-by-case basis, we could see substantial savings in assisting families who wanted to provide a better place for their children to grow other than an institution to meet their children's needs at home.

With the model waiver, we saw a greater number of individuals being served with the States making the determination to waive restrictions on parental income so that current or basic Medicare services could be provided outside of institutions. That made life a little easier for those who were able to be identified by State agencies understanding the waiver process.

Home and community-based waivers could show substantial cost savings by the realignment of services. Instead of limited, expensive hospital-based care, home- and community-based waivers provide more comprehensive, extensive community-based services. Further, through the development and coordination of these services, communities come to understand, prepare for, and respond to the disabled person—a vitally important preparation and understanding if alternatives to institutionalization are to be more widely available in the future.

Costly care need not be essential in the future if we have these home- and community-based services in place and developing through current State programs.

I will conclude by saying that these waiver programs have been successful. Incentives need to be provided to the States for expanding home- and community-based services and waiver programs in general.

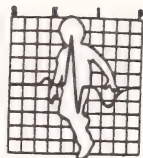
You can see before you an example of how successful waivers can be. This is not a political issue. It is not a short-term, today-only issue. We as a society need to prepare for the future—all of us—both sides of the aisle—the public sector working with the private sector—to support these medically fragile children and their counterparts, the elderly and the mentally disabled.

Each person has potential for growth, for development, at any age. We must help each to receive the care which will best promote that growth, which will enhance their quality of life, and thus the quality of life of all of us in this Nation.

Thank you.

[The prepared statement of Ms. Julie Beckett follows:]

SKIP
Sick Kids
need Involved People



June 11, 1985

Gentlemen

We appear before you today as a family - a typical All-American middle class family. You may say "not so typical," but on the outside on the surface that's how we look.

Mother and father - fairly intelligent, college-educated, broad range of interests, in fairly good physical shape.

Daughter - 7 years old - 2nd grader, Brownie, pretty, intelligent, inquisitive, rambunctious - but wait a minute! something is different. She has a funny necklace on and she carries a bag; I think it's a gym bag - not a purse.

Those who look more closely can see - the love and the caring shared by this family - but few people see the sadness - for nowadays there is little sadness. They surround themselves with happy things - time shared, as most families do with picnics, travels to grandparents houses, lessons to be learned, television shows to be watched, prayers to be said - vacation to go on. But are you getting the real picture.

Why is she wearing that necklace - let me give you some reasons:

- 1) She can't breathe while she sleeps without a mechanical device to help her.
- 2) She needs three treatments a day, which mom and dad perform, to keep her lungs clear.
- 3) A machine follows her wherever she goes and a person who knows how to operate it,

and finally that little gym bag is filled with catheters, gloves, syringes, food, medication and most importantly a gastrostomy tube, a trach and an amber bag.

You see she's what the experts, the professionals call a medically fragile or medically vulnerable child. Words that everytime I say them seem more and more unusual.

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 301-987-0425

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 319-362-0978

Texas
 609-755-0555

New York
 212-734-0720

Affiliates:
 Illinois
 312-631-0030

Chapters Under Development:
 Virginia, North Carolina, South Carolina,
 Pennsylvania, Michigan, Florida

Oh! Well then she's not your typical middle class American child. - Don't Count on It - today because of all the new things introduced in our lives in the last 30-40 years - along with the successes come some of the failures - along with the good comes some of the bad - more severe illnesses, more complex illnesses and new and wonderful ways to treat them. Our society is changing - our society has changed - it's coming of age and we have to prepare for it.

You are the people to help that change.

We're still the typical middle class American family, but we've been given a reprieve. We went through the sadness, the heartache, the illness and we are fighters. We've met the dragon - we've looked him in the eyes and we have defeated him. Maybe! My father always says to give yourself an out. This whole trip was almost cancelled because that evil thing called "infection" came to call on us a week ago. But as I said before, "we are fighters" - clarified Katie's a fighter, and she has two good people in her corner who gear up everytime something looks funny.

It takes a simple call to the doctor's office and the force is with us - never discounting the Hail Marys and the Our Fathers that fly off in between.

But lets get back to what makes us different - we're not so different - we want our child to grow up in the most normal fashion possible - in her home - in her bedroom in her classroom - in her Brownie day camp. All things provided because people named Ronald Reagan, George Bush, Richard Schweiter, but most assuredly Tom Tauke, Janet Hart, and Hazel Wharff, one of our dearest friends - and a man that few people will remember as being instrumental in our getting home - Daniel Schorr. Interesting - hugh! I'll never forget when he stood up at the end of that news conference and clarified what the President had said before about "hidebound regulations" because I knew that would seal our package home. And I'll never forget meeting one of the six men who worked for 72 hours to find that little section in the Omnibus Reconciliation Act of 1981 which would apply to our case - our friend Fred Abby.

I can never express how grateful we are to each and everyone, and to the hundreds of others who have the same opportunity because the door was open and caring people like Surgeon General Koop, Margaret Heckler, Dr. Carolyn Davis, Dr. Merle McPherson, Dr. Vince Hutchins, Camille Cook, Bob Wren, Bob Wordwell, Dan Converse, Fred Abby, Michael Batten and hundreds of others were waiting to help, not to hinder.

These people, especially the last four, have done more to help the model waiver and the home and community-based waiver succeed - and certainly they have been successful but there is still a long road to hoe.

I cannot speak today without mentioning the people who have tried so hard - but they are too many in number - some of them however are here and should be recognized.

Tammy West and Patti Bearpaw who as mothers fought for the waiver in New Mexico.

Marguente Mikol, who almost solely convinced the state of New York - the Governor, the State Medicaid Director, the whole Social Service System that children in New York can live outside a hospital if they had a waiver.

Helene Clark, a mother who would not relinquish her hold on the Texas Medicaid Department until they finally gave in and applied for the waiver.

Bette Wingel who lived desperately for years until they finally were able to secure an individual waiver for their late daughter, Tudy.

Karen Shannon, my ally and my friend, who helps more people by support, by utilizing the resources she has - who helped to develop the Maryland waiver and the entire S.P.R.A.N.S. grant project in Maryland - unfortunately they didn't let her run it on, we'd have more kids home. She is the founder and director of SKIP.

These people are recognized as S.K.I.P. - Sick Kids (Need) Involved People. They're here to support the thousands of children still in desperate need of support.

Has the waiver been effective? - As I speak around the country a resounding "Yes" comes to the fore. But is it enough, what do families need, what to these taxpayers need?

There are more families than you can count who have insurance - insurance that will run out soon. Have you ever been in a situation where someone who is ill eats up hundreds of thousands of dollars every year - hopefully not. Well, we have, we prepared, we carried good insurance - million dollar policies that ran out in a very short period of time - then what - what is the answer?

The answer lies in a cooperative effort. Public and private funders, state insurance commissioners, major self insurance companies must come together to meet and solve the problems plaguing a great number of families in our situation.

The Medicaid system cannot encompass all of these children and they shouldn't have to. We work hard, we pay taxes but we also continue our health insurance and we deserve an even break, just like everybody else. We must as a society produce a new alternative to health coverage for the chronically ill - technology dependent child and his or her family. We are not unique anymore, our numbers are growing in leaps and bounds.

As parents we want to share the responsibility for our children and their lives. It is frightening as a parent to have a child with a wonderful potential for a successful life, facing no health insurance coverage whatsoever. You wouldn't live without, why should they have to. Why build a society dependent on welfare - don't we already feel the ramifications for that. These parents and the professional who care and develop programs for them want to voice their needs and we can as a society do more to move ahead. Understanding has begun amongst our peers, amongst the health care professionals, even amongst the funders and believe me not without a lot of sweat and tears.

I went on my own and with others to educate many persons from the Health Insurance Association of America, Blue Cross, Blue Shield, American Hospital Association, many members of Congress, many members of HCFA, both state and federal agencies and many members of HGRSA, just to name a few.

We have agreed, we can help, we can work together - but we need the opportunity to come up with a solution.

The federal government's responsibility should be to provide a forum for this and incentives to achieve this.

Until this meeting, this consensus, this forum takes place, we must support what we have - the waiver program can and should continue. The successes of Dr. Davis, Fred Abby, Dan Converse, Bob Wren and Michael Batten must be saluted.

They have done everything to convince the states that the waiver programs will help these children. The states who have complied and those who are complying should be saluted and those states who have not should be convinced to help.

It should not be more costly, how can it possibly be - when children are home and being cared for by their parents - even if those parents have help in the home - room and board alone saves many dollars.

Help us - we will continue to educate, but you must help us.

These are not the only problems which face our "new generation," quality assurance guarantees, professional training are among others, but those are being dealt with - again through education (our educating them). But without the financing - we cannot do anymore. We must settle this problem which can be resolved.

Help us - we will do it - we must - they are our children. The hope for the future, the future lies in their hands - lets prepare them for it.

Julianne Beckett
Program Assistant

JBe:06/11/85mm

Mr. WAXMAN. Thank you very much. It is excellent testimony. I want to commend you on it.

We in the Congress sometimes find ourselves in a three-ring circus. We have this subcommittee meeting, but we also have our full committee meeting at the present time, and in a little while we will be meeting in the House to discuss and vote on the defense bill. Our full committee asked us if we could break just to record our presence for a quorum so they can have people continue doing business. We are going to take a very brief recess of around 5 or 10 minutes, and we will be right back.

[Brief recess.]

STATEMENT OF BEULAH KINES

Mr. WAXMAN. I would like to reconvene the subcommittee. Ms. Freeman, we are pleased to have you here and your mother, Ms. Kines. I would like to hear from you at this time.

Ms. FREEMAN. Thank you.

My name is Ada Freeman. I am one of eight children. I am married, I have two sons. One is married and does not live at home, one 4 years old at home.

My mother, Beulah Kines, is 77 years old, and she has lived with me for about 3 years. She moved in with me due to her own inability to care for herself. And since none of my brothers and sisters were able to care for her—one sister and two brothers are disabled—I do not want to put my mother into a nursing home.

On January 25, 1984, I took my mother to the welfare office to see about getting nursing care. She was screened for nursing home care. The Virginia Department of Medical Assistance Service advised me that in-home care was available.

They came to my home to check on my mother's condition. She could hardly walk, slept most of the time, had arthritis, diabetes, and was confused. She hardly recognized her own children. She suffered a partial stroke in January 1984. I would not have the energy to care for her alone plus care for my little boy without personal care service provided by Nona Walton and her company.

I could not do my own grocery shopping for I cannot leave my mother alone. I could not handle both my son and mother while trying to shop. My mother's income from Social Security and VA pensions is \$463 a month. She receives 27 hours a week, 117 hours a month from the personal care agent for which she pays \$202 a month. It keeps her plan of care cost effective so she can continue to receive personal care.

I was allowed to set up my own schedule as both my son and mother get up at around the same time. So I set it up for Monday through Thursday from 8 a.m. to 1:30 p.m. and on Friday from 8 a.m. to 1 p.m.

She has had therapy. She had to have therapy to get her hands working. She couldn't use her hands from arthritis, and after the therapist worked with her and different ones of them worked with her, she is now able to use her hands.

Mr. WAXMAN. This waiver has been pretty important then, to have her stay with you?

Ms. FREEMAN. Yes; I wanted her to stay with me more than anything. I still want her to stay with me and be able to take care of her at home. We could never do it without the help of the personal aid care at home.

Mr. WAXMAN. Thank you very much. That is exactly the kind of thing we want to have happen. I am pleased to hear about it. Thank you very much.

STATEMENT OF JOHN RANDOLPH

Mr. WAXMAN. Mr. Randolph.

Mr. RANDOLPH. My name is John Randolph. I live in Trenton, NJ. I am 55 years old. I have spent 46 of my 55 years living in State institutions for the mentally retarded.

I am here to speak in support of extension of the community care waiver. I would like to tell you about my life so that you will know how important it is that people like myself get out of the institutions and get support for their new lives in the community.

I was born in Hackensack in 1930. I lived at home with my parents until I went into kindergarten. In school I had speech problems, and they said I was a slow learner. They told my parents that I should go into a state training school. I was 7 years old when my parents put me into Vineland Training School.

When I first got to Vineland Training School, I was too small to know what was going on. They gave me a bed in a big dormitory. My name was on a nameplate on the bed. I didn't have a closet or a dresser. Everything I used was kept under the bed. The dormitory where I stayed as a little boy had men in it of all different ages. The room where I spent most of my time had no curtains or rugs. It was not like a home.

I grew up at the State school. When you got up in the morning, the place where you ate breakfast and other meals was right in the area where you slept. I went out to work on the grounds. I worked on planting flowers and in the greenhouse. I did not get paid for the work.

There was no freedom at the State school. The only time I left the grounds was when my parents came to take me out. I always had to stay and sit in a place where a staff person watched me.

The institution where I grew up was set up with men on one end of the property and women on the other end. The only time we were allowed to associate was during parties. No one had boyfriends or girlfriends. It was not allowed.

In 1957, I was moved to Woodbine State School. It was better. You were allowed to learn skills like housekeeping and cooking. After I was there for 2 years, I was made an institutional aide. This meant I was allowed to go around the grounds by myself. I had a job as a messenger at Woodbine, going around the grounds delivering mail. I was paid a small salary which went into a savings account.

A few years ago when money was made available through the Federal Government so people could leave institutions, I was released. Before I left Woodbine State School, the other people I lived with gave me a party. They gave me presents of things to wear and

things to use. I still keep in touch with my friends at the State school and hope that some day they can come out.

I moved from Woodbine State School into a supervised apartment run by the Association for Retarded Citizens. This supervised apartment program is supported by the Community Care Waiver through the Division of Mental Retardation. The Federal money put into community services was a lot of help to me. I had a case-worker who made sure I got settled into my apartment. A place was found for me to work in a sheltered workshop. At first I was driven to work in a van. Then I was taught to ride the public bus to the workshop.

Being able to live in the community was a big change for me. When I first walked into that apartment with its living room, bedroom and kitchen, I felt like I was finally back in a real home.

I stayed at the sheltered workshop and learned job skills, doing work like mailing, labeling and stuffing envelopes. In the supervised apartment I learned how to take care of my own place. During the time I was there I got help from the Division of Mental Retardation.

In November 1984, I got a real job at the State Sales Office Furniture Equipment in Trenton. The counselor at the workshop helped me get the job. My job is to clean up and fix used furniture to make it ready to sell.

On January 3, 1985, I moved into my own apartment in a senior citizens complex in Trenton. I am now on my own and have my freedom. I come and go as I please. I handle my own affairs and I am my own person. I go around to the shopping areas whenever I want. I have a girlfriend who I have known for 3 years. We may get engaged next spring. I am active with the Boy Scouts as a scoutmaster. I now have a drivers license.

I am also involved in the self-advocacy movement for mentally retarded people. The self-advocacy movement involves disabled people learning to speak up for themselves and each other. It is self help. I started a self-help group for mentally retarded people in my home town of Trenton. I was also elected president of the State-wide New Jersey Self-Advocacy Organization. This organization has 300 disabled people in it who are members of 22 self-advocacy groups in New Jersey.

As you can see, my life has changed completely, and to tell you the truth, it is a wonderful life.

I am asking you to continue the community care waiver. Without the kind of support the waiver gives, my life would not have changed as it did.

I am more fortunate than most people still in institutions. I can speak for myself. I am speaking today on behalf of those who cannot speak for themselves.

I hope you will extend the community care waiver so that others that I left behind in the institutions can come out and be free.

Thank you for having us here today.

Mr. WAXMAN. Thank you very much, Mr. Randolph. You have given us a remarkable success story. You should be very proud of what you have been able to accomplish. We want to help other people to be able to do the exact same thing you have been able to do. Thank you very much.

Ms. Trapp.

STATEMENT OF MERILEE TRAPP

Ms. TRAPP. My name is Merilee Trapp. I live at the Kane Hospital in Pittsburgh. I have lived in Kane for 15 years. I am 37 years old. I can't even talk to my roommate. He does not speak English. I think it is a crime that they don't understand the people—young people, like me, should have a chance in the community. I think it would be—it cost more to keep me in Kane than in the community.

The average age at Kane is 78 years old.

Mr. WAXMAN. The average age of the people is 78 in the nursing home where you are? And you are 37?

Ms. TRAPP. Yes.

Mr. WAXMAN. You would like to be able to live at home rather than to have to be in that nursing home?

Ms. TRAPP. There are two other girls my own age. It would be much better. I can't go shopping myself. I don't have any control over my life. I would love to be able to do those things. I could go to parties instead of going to bed at 7:30 just because you are in an institution.

At 7:30, when you get ready to go out for the evening, people like me in institutions are already getting ready for bed. I don't think it is fair that young people like me—all the young people at Kane, they don't need to be in there. They have this opportunity to get out and show the community we can be a valuable resource in the community instead of sticking us in institutions. I think it is just hard—it is hard to understand.

Those people have their lives, but I would like to experience different things. If I am in Kane, I cannot do that. This is the first time I have been to Washington. I was really nervous this morning, so you have to forgive me.

Mr. WAXMAN. You are doing fine.

Ms. TRAPP. Thank you very much.

[The statement of Merilee Trapp follows:]



STATEMENT
PRESENTED BEFORE THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
OF THE HOUSE COMMITTEE ON
ENERGY AND COMMERCE
ON
MEDICAID HOME AND COMMUNITY CARE AUTHORITY
ON BEHALF OF

UNITED CEREBRAL PALSY ASSOCIATIONS, INC.

THE CHESTER ARTHUR BUILDING
425 "EYE" STREET, N.W., SUITE 141
WASHINGTON, D.C. 20001

Witness: Merilee Trapp
Kane Hospital
Pittsburgh, PA

Accompanied by Al Condeluci, Ph.D.
United Cerebral Palsy Association
of the Pittsburgh District
4638 Centre Avenue
Pittsburgh, PA 15213
412-683-7100

June 25, 1985

Good Morning Mr. Chairman:

My name is Merilee Trapp. I am 37 years old and I am a resident of Kane Hospital Ross Regional Center. Kane is a large intermediate/skilled institution primarily for the aged. There are 360 residents, with 90% over 60 years of age. I have lived in Kane for almost 15 years, being admitted in 1970. At that time my mother could not care for me at home because she had to work.

As you can see, I have cerebral palsy and need some assistance in personal care. But I am not sick. I am in no need of nursing care, which is primarily what Kane offers. The only reason I live at Kane is because the services I need cannot be paid for under Title 19 in the community.

I appreciate the opportunity to come and speak with you this morning. It's not often that we in institutions get a chance to do things like this. In fact this is the first time I have ever been to Washington, D.C. I am not afraid to tell you that I am a little nervous.

I am here to day on behalf of all physically disabled young persons like myself who are stuck in institutions. I don't know if anyone here has spent time in an institution but it isn't fun. Most of the residents in my institution are frail elderly. It is very depressing and frustrating for me. I tell my friends that institutions are nice places to visit, but you wouldn't want to live there. There is no privacy, you have no control, and most of the time we are treated as if we are sick. Don't get me wrong Kane does good things, but as I said it is primarily for the elderly. In fact, the average age at Kane Ross is 78. Yet in the state of Pennsylvania there are thousands of physically disabled people my age living in ICF's.

My life at Kane is dull. Sure there are activities, but they are set up for the elderly; bingos, things like that and after 4:00 the place more or less closes up. When people my age are just starting to have a good time, we in institutions are getting ready for bed. Some people in my room go to bed at 7:30, some even earlier. Yet the wailing and night long crying often keeps me awake.

Right now the only times I ever get out of Kane is when I attend the Independent Living Program at UCP in Pittsburgh. Boy do I look forward to those days. At UCP I see other people like myself who are learning to be independent. I'm treated like an adult not a patient and it makes me feel good. These kinds of programs teach us how to manage money, cook meals, and deal with community situations. Yet the new waiver regulations disallow these types of programs and make the unfair assumption that prevocational programs do not lead to self-sufficiency. It is outrageous and personally insulting to me that whoever wrote these regulations don't understand the link between prevocational services and remaining in the community. (See Appendix A).

I don't understand all the details but my friend, Al Condeluci, who works at UCP has applied to the Federal Government for a waiver to set up community services to help me and many of the other young physically disabled residents move from Kane. He has done this for a lot of other clients of UCP who are retarded, using state funds and they are doing great. These people are doing the things that folks like you do. They go to the store, movies, go out to eat, go to sleep when they want. I know this because I have had the opportunity to spend a few weekends with these friends and have seen things firsthand.

The waiver Al worked on was designed to help people with physical disabilities like me, who are not retarded, have the same chance. Although I try not to get my hopes up too high, I am excited about the possibilities for me in the community. I dream about it. To have friends over and to take care of my own affairs. To be treated like a real person in my own apartment seems almost too good to be true.

I understand that our waiver was not accepted because we were compared to the elderly in the confusing formula we had to use (see Appendix B). Why is it that this always happens? Why do we always have to be compared to the elderly? We are different? Sure we may have some similar attendant care needs, but to make me live with people 80 and over is unfair. My present roommate is 88 years old and can speak no English. I can't even talk to her!

I am not sure if my testimony today is helpful or not, but I wanted you to know what it is like for someone like me. The waiver offered me an alternative to living at Kane. It saddens me that the new regulations create even more barriers. I always thought Congress gave us the waiver demonstrations to be flexible and to try new things. It's a shame that this administration has made the waiver process so prohibitive.

Please remember that we disabled are not asking for handout - only a chance to live a more meaningful life. The waivers offer such an opportunity.

In closing, I want to thank the Committee for allowing my testimony. I would like the Committee to consider the following points if I am ever to have a chance of getting out of Kane Hospital.

1. I urge Congress to develop a legislative response to these regulations which stand in the way of my returning to the community.
2. Please allow for the funding of prevocational, educational and vocational services under waiver programs. They are essential and cost-effective to my remaining in a community setting.
3. Please adjust the waiver formula so that younger physically disabled individuals like myself can benefit from the waiver as the elderly do now.

I turn to Congress to make these changes. My future rests with you.

Thank you.

VOCATIONAL/PREVOCATIONAL ISSUE

APPENDIX A

The new waiver regulations indicate that prevocational and vocational training and educational activities may not be provided under the Home and Community Based Services Waiver. They state: "We do not believe that prevocational and vocational training and educational activities are normally furnished as a means of avoiding institutionalization."

United Cerebral Palsy Association of Pittsburgh takes vigorous opposition to this statement. We believe strongly that prevocational, vocational and independent living activities are related to preventing institutionalization, and we have recent program figures to document this position.

Since January 1981 UCP of Pittsburgh has graduated 60 severely disabled men/women from an Independent Living Rehabilitation Program that teaches skills such as money management, meal preparation, personal care, etc. These things are classic prevocational skills.

A profile of these graduates is as follows:

o age at entry: average 28.6 years, range 19 - 51 years

o disability:

Cerebral Palsy:	65%
Spina Bifida:	10%
Head Trauma:	8%
Learning Disability	7%
Other:	10%
(one individual each with arthrogryposis, spastic quadriplegia, dystonia, epilepsy, spinal cord injury and polio).	

o disability onset:

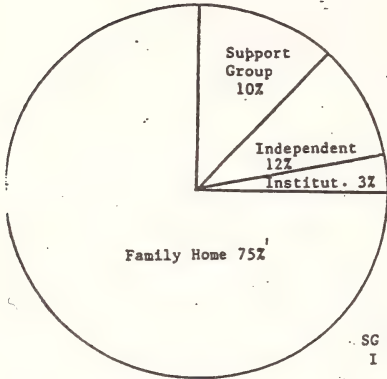
congenital:	83%
acquired:	17%

o mobility status:

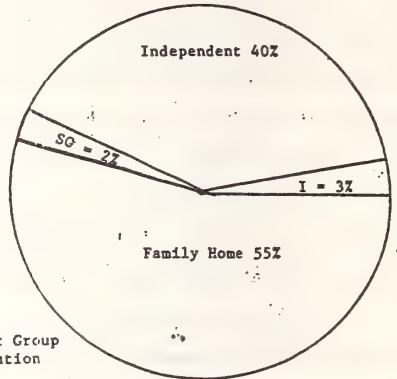
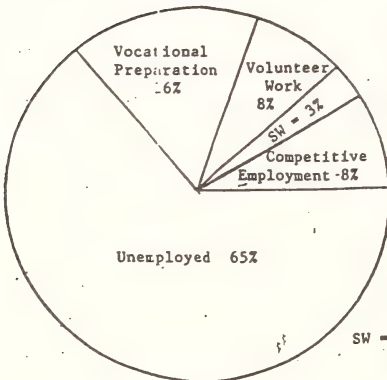
ambulatory:	53%
uses wheelchair:	40%
uses wheelchair, but ambulatory for short periods:	7%

o speech involvement:

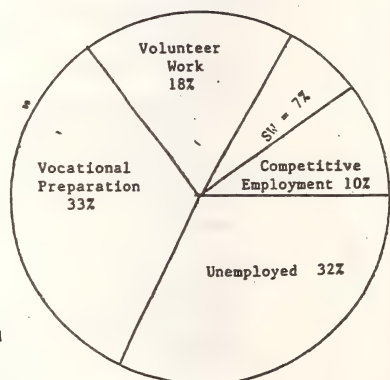
no speech difficulties	63%
mild impairment:	20%
moderate impairment	12%
severe impairment/nonvocal	5%

LIVING SITUATION OF ILRP GRADUATESPREPROGRAM

SG = Support Group
I = Institution

JANUARY 1985VOCATIONAL ACTIVITIES OF ILRP GRADUATESPREPROGRAM

SW = Sheltered Workshop

JANUARY 1985

As you can see from these pie charts, many of these graduates have moved from their family home to their own apartments. Some of these folks were clearly at the risk of institutionalization and after receiving the prevocational classes, they were able to become more independent and prevent their institutionalization.

FORMULA ISSUE

The intent of the waiver jurisdiction was to save federal money and to offer the states more flexibility in providing Title 19 services. The present formula for the waiver does neither.

The waiver project submitted by the State of Pennsylvania Department of Public Welfare is a perfect illustration of how the present waiver formula falls short.

The Allegheny County Waiver Project was designed to deinstitutionalize 144 severely disabled mentally alert adults from ICF's/SNF's in our county over three years. The project is unique in that most waiver projects have been designed for either preventing institutionalization of the elderly or deinstitutionalizing mentally retarded folks from ICF/MR's.

As we developed our waiver the formula became prohibitive in two major ways:

- 1) Even though we wanted to serve younger adults, we were held accountable to aggregate figures that included elderly. These two groups are clearly not comparable. The average length of stay in an ICF in a given year in Pennsylvania is 207 days due to death and discharges to family or acute care facilities. Members of the younger disabled population, however, generally reside at the facility year 'round. In sum, HCFA requested that UCP serve deinstitutionalized clients 365 days per year with an eligible reimbursement rate based on 207 of those days, in spite of the fact that the actual current Medicaid institutional costs for the younger population covers the entire year.
- 2) As Pittsburgh is located in an urban area we are subjected to a higher cost of living. Yet, by using the statewide aggregate statistics and costs, the per capita figures we are compared to are not fair. The overall per capita for Medicaid spending is less on a statewide average than in our urban area of Allegheny County.

These two points clearly indicate that Congress needs to adjust the formula to allow for like comparisons to like beneficiaries and regions.

Mr. WYDEN. I think you are a pro.

Mr. WAXMAN. The fact that you are here to talk to us is especially important to us. You are in a nursing home where the average age is 78. You would rather be able to live in the community with some assistance. That independence is really what we wanted when we passed the 2176 waiver.

Ms. TRAPP. A man is 88 years old, and I can't even talk to him. I just want to thank the committee for giving me the opportunity to speak up for everybody at Kane.

Mr. WAXMAN. Thank you.

Ms. TRAPP. Thank you.

Mr. WAXMAN. I appreciate your taking this opportunity to not only speak on your own behalf but others as well. It is very important to us. Thank you very much.

Ms. TRAPP. I hope you continue the waivers to cover me also, the waivers.

Mr. WAXMAN. Thank you very much. Let me thank all of you for your testimony. It is very, very helpful to us.

Ms. Beckett, Ms. Freeman, and Mr. Randolph, if your Medicaid waivers were to end, what would happen to you? Mr. Randolph, if you didn't have that waiver, would you have to go back to an institution?

Mr. RANDOLPH. If that waiver would end, no, I prefer staying out.

Mr. WAXMAN. You would rather stay out. If you didn't have that waiver, it would be difficult for you, wouldn't it?

Mr. RANDOLPH. Yes.

Mr. WAXMAN. Ms. Freeman, how about your mother?

Ms. FREEMAN. It would be very difficult, but I would keep her with me as long as I possibly could.

Mr. WAXMAN. Ms. Beckett, what would be the situation with Katie? Before she was in an institution, then the waiver allowed her to stay home. If we didn't have anything like this waiver, do you expect she would have to go back?

Ms. JULIE BECKETT. It would be impossible for us to pay \$36,000 a year in home care costs, of course. I think, though, that because of the things Katie has been through and because of the incidences of the people who are sitting on this panel, it is evidence enough for the majority of society that those waivers have benefitted a number of the population. I don't see that that is a reality, but I do see that it is very difficult for families out there who have not gotten these waivers and have not been able to participate for a number of reasons, not just because they are not eligible under Medicaid, but necessarily because there has been a lack of understanding of what can actually be provided for these families and the success stories are extremely important.

I think, too, we have to look at the fact that alternative funding sources have to be found beyond just Medicaid programs. Private insurance is moving towards helping individuals such as these who are not Medicaid bound, and we are at this time bound by that.

Mr. WAXMAN. We, as a society, said we are going to have a program called Medicaid for the poor. A lot of people are not eligible because they have a part-time job or they have a little money. But once a person is eligible, we are obligated to pay for their health care services.

It seems to me, given your experience, that we ought to allow every opportunity for the States that run that program to allow people to stay at home or be in some community program rather to put them in an institution.

Ms. JULIE BECKETT. I think that is a very important point. I think one of the things—what you are actually saying and what I think the Federal Government's responsibility in all of this is providing a forum for families such as ours, such as the panel members here, to give testimony to and to help direct new programs to be established, particularly pulling together the public and private sector, not just the public sector. It has to be from both sides of the fence.

And what you are saying is absolutely true. Those waiver programs are an absolute necessity, but private insurance is willing—I have been there myself. I went to the Health Insurance Association of America, I have been to Blue Cross-Blue Shield voicing the needs and concerns of hundreds and thousands of families across this nation who have health insurance and who want to be able to bring their children home and who need new programs established, who need alternative health care funding, and I think new alternatives can come up.

Mr. WAXMAN. We need to try some of these ideas out.

Ms. JULIE BECKETT. That is right. And the Congress is the perfect place to establish some sort of body which can examine what alternative health care funding can be provided. I mean, you are the Federal Government, you are the voice of the people, and you are representing all of us. This population is not getting smaller, it is getting larger. We need to know how to take care of that population and prepare us for the future.

One of those—I work for an organization called SKIP, "Sick Kids Need Involved People." We are a group of parents. We are parents who believe new resources can be provided, that new alternatives can be accessed, that you can coordinate the services that are already out in the community to provide and to access care for these kinds of kids and for every member of our society.

And I think that one of the most important things is if we can come up with a concept of even a high-risk pool that would allow, for instance, chronically ill children, let's examine that, let's see what is willing—can Medicaid fund part of that and can insurance buy into something like that? So far everybody I have talked to seems to feel that could be an alternative, but nobody has taken the time to do that. Let's see if we can't.

Mr. WAXMAN. That is very good point you are raising. Thank you very much.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman. Hats off to all of you as panel members. It is fine to talk about these things in the abstract and to talk about statistics and figures, but all of you are concrete success stories and, as such, you are an inspiration to all of us.

Let me make a quick comment, and then I have just one question. Ms. Beckett, you talked about your view that the waiver program should not be political.

Ms. JULIE BECKETT. That is right.

Mr. WYDEN. Would it really be possible to have such an arrangement? That is what Congress intended in 1981. But ever since 1981, the administration has tried to ratchet down this program and has thrown up every conceivable obstacle to try to run an effective waiver program. That is why the States are so unhappy.

They are unhappy even with the March 13 regulations. My State did a survey, and 94 percent of the States in this country are unhappy with the March 13 regulations. So I just wish we could have the ideal arrangement where politicians weren't calling the shots. One of the reasons more people aren't in this program is because there has been political interference. What we started in 1981 was a superb arrangement, and it is just too bad it has gone astray. We haven't been able to serve as many people because of politics.

Let me ask you a question with respect to your counsel to families, because I think you can give us some really good advice in this regard. What do you think a family ought to be able to demonstrate, a hypothetical family, to be able to qualify for home or community-based services?

Ms. JULIE BECKETT. I think, Congressman Wyden, there are a number of things that families must demonstrate and families can demonstrate. One of those is the fact they want the responsibility of taking care of their family members, that they want to be able to provide some of that care themselves, and that those families can and do want to provide that.

Also, we have to see, and they have to be able to provide that the quality of care will remain the same or improve as the person leaves an institution. The last part of that, and because this is important, and it is important, and I think that this whole concept of financing of care is so important, that we have to look at the fact that if the income is—excuse me, if you can demonstrate that cost would be equal to or less than what is currently out there, and what it is costing you in an institution, why aren't they home?

Well, I think, you know, your statement before about political issues, there is a number of problems with political issues, and one of those, I think what you are voicing is somewhat true to a certain extent. I can look at the other end of that, after each one of these little appearances that we do on behalf of children who are chronically ill and technology dependent, those who cost the most, I get hundreds of calls from across the Nation, from families who say "What do I do now? What can I do?" And when I call on people that have helped us in the past, they are more than willing to help. They have done as much as they possibly could and bent over backward to try to find some way to fund and to service these kids, particularly in my own State. But around the Nation they want to access services to these kids.

We have had incidences where children have been used as political ploys between both parties, and that is wrong as far as I am concerned. It is something that shouldn't happen. This is everybody's problem, and this is something—you may not have a chronically ill child, but that doesn't mean you might not in the future.

There are so many new things happening today, more complex illnesses, more severe illnesses, more accidents, more birth defects, more problems that are difficult to find answers for, but technology

is providing the forum for them. They are helping them to survive. Now we have to prepare for that.

Mr. WYDEN. The only point I think is central is the arrangement for coming up with nonpolitical solutions. That is why I think Senator Bradley's bill and mine is the way to go, because there would only be one judgment, not a whole bunch of regulations that can be subjective. Under our legislation, the only judgment that would matter is what you testified to, that is you can save money, and it is not as expensive as other Medicaid arrangements.

Ms. JULIE BECKETT. And I agree with that. I agree with that bill in particular. But you also have to look at the fact that what you are demonstrating there is just public funding. What about the private sector? We have had insurance companies who have walked in and said, "Well, we will pay for the 3 months, or whatever—we will send you home, but in 3 months, we are out of it, you go get a Medicaid waiver, you can qualify for one of those, the Government is handling that."

That isn't right either, is it? We can't have that. We have to have—that is why I say it has got to be a joint effort on both parts. It can't be just one sided.

Mr. WYDEN. You brought up the perfect point to end on. Several weeks ago I introduced legislation, the Private Long-Term Care Insurance Act, to promote private insurance companies to get into the field, and I agree with you, that is the wave of the future.

Ms. JULIE BECKETT. We are going to need a joint effort. And I think that that kind of a forum should take place within this particular body.

Mr. WYDEN. You are an inspiration to this committee. Thank you for coming.

Mr. WAXMAN. You have been very, very helpful in your testimony. I know some of you have traveled long distances, we appreciate it. It is not easy to come and talk with Congressmen. You did a superb job, you got your points across and those points you raised with us are exactly what we have to keep in mind in designing our health care programs. We don't want to leave people in institutions if they can be function well and have their needs met in the community. Thank you very much for being with us.

We are going to get the State officials' perspective on the 2176 waivers.

Our first witness is Ms. Barbara Matula, director of the North Carolina Medicaid Program. North Carolina has one approved waiver that covers the aged and disabled which is scheduled to expire on June 30, and a renewal application is pending. North Carolina has a waiver in effect for the mentally retarded as well as a model waiver for disabled children.

Joining her on the panel is Mr. Richard Ladd, the assistant director of the Oregon Department of Human Resources. Oregon was the first State to receive approval for a 2176 waiver in December 1981. The State now operates two approved waivers, one for the aged, disabled and mentally ill and the other for the mentally retarded and disabled.

The final State official is Carol Kurland, administrator of Home Care Programs. New Jersey has two approved model waivers for

disabled adults and children as well as waivers for the aged and disabled and for the mentally disabled.

We want to thank you for appearing before the subcommittee this morning. I recognize other State officials share your view, some of whom were not willing to come forward and testify. They are afraid there may be retaliation. I hope that would never be the case.

But to whatever extent being here to testify before a committee of Congress amounts to being courageous, we appreciate your courage and being with us today. We are going to appreciate your input because we have to work with you on these programs.

Ms. Matula.

STATEMENTS OF BARBARA D. MATULA, CHAIRMAN, STATE MEDICAID DIRECTORS' ASSOCIATION OF THE AMERICAN PUBLIC WELFARE ASSOCIATION; RICHARD C. LADD, ADMINISTRATOR, OREGON SENIOR SERVICES DIVISION; AND CAROL H. KURLAND, ADMINISTRATOR, OFFICE OF HOME CARE PROGRAMS, NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Ms. MATULA. Thank you. It has often been said I have more guts than brains. I am chairman of the State Medicaid Director's Association, as well as the State Medicaid director of North Carolina, and I think that the States are as enthusiastic as you folks are about the concept of the waivers, but our experience with the process has been less than a happy one.

The program came about, as you recall, in an era of budget cuts, and rather than being simply restrictive, Congress gave the States in 1981 new flexibility in this and some other areas so that we could absorb the cuts without harming the programs or the recipients. We share the cautious approach HCFA has institutionalized, I suppose, in that we too have been burned in the past. We don't want to go into a wholesale expansion of services that would become a monster for us to handle.

We really appreciate the waiver opportunity that we can experiment with this program, start small, learn from our mistakes if we do make them so that we don't institutionalize our errors, and prove to our State legislatures and to you folks that we can run an effective and efficient program and provide good quality care.

Well, the waiver program has not lived up to our expectations. If I am here for any one reason, it would be to return the good connotation to the word "flexibility." It has really earned a very bad reputation in the last 3 years. I will give you some broad reasons why, and I think the State panelists that follow me can be more specific.

We feel that these final waiver regulations are going to actually deter States from seeking more waivers or even pursuing some of their renewals. It seems the key in the cost-effective formula is to ensure that this program does not cost the Federal Government or the States any additional money.

But what has happened, I think, has become an incredibly unnecessary waste of our State effort and our time way out of proportion to the program that we have undertaken. We have had to produce excessive assurances and documentation to receive our

waivers or renewals. The final rules call for even more data and substantiation, and I know data is a very dull and boring subject, but when you spend more to accomplish reporting requirements than you can save by implementing the program, it becomes a serious issue for the States.

I have to emphasize one very important point. HCFA and OMB are not alone in their concern for budget neutrality. We share that concern. We do not wish to open the door and run our transportation budgets through the Medicaid Program. We want to make sure that we are handling this in a very fiscally responsible way.

But the controversy I think that surrounds it now and the budget neutrality issue is how it is being monitored and how it is being enforced and how we are being judged, in fact, through the cost effective formula. Let me give you three examples of the unfairness found in the formula.

We know that it rewards States that have built nursing home beds, even excess capacity nursing home beds, and it penalizes States that have controlled bed growth. This is a very important point to us. HCFA requires that States submit documentation on the number of beds that would be built if no waiver were granted. So for States like North Carolina that have enacted a freeze on nursing home beds, we can't show growth. We are then limited artificially to the folks we can serve in the community by the number of beds we have built.

Obviously, if a State had no CON process in place or if it was on the high end of the scale in numbers of beds per thousand for the population over 65, it now is in the enviable position of being able to serve more people in the community because it is in fact overbedded. This is a perverse incentive: If you are overbedded, you can now serve more people. If you are underserving nursing home patients, you can serve fewer patients in the community.

The final rule also places a limit on total expenditures for home and community-based services under the waiver. This limit imposes an unwarranted burden on the States, and it clearly has no basis in the statute. The law says that in order to receive the waiver, a State must show the average per capita expenditure for medical assistance in that fiscal year for individuals covered by the waiver doesn't exceed the average per capita expenditure if the waiver had not been in effect.

The formula does anything but this. We must show and we must assure—have assurances on an annual basis that our total expenditures for these home and community-based services will not exceed the amount we estimated.

Now, this means that Medicaid directors have to become seers. We cannot exceed the amount we estimate, even if the amount we spend is less than what the institutional costs would have been. FFP is not allowed on the amount in which we exceed our estimate, and we can lose our waiver by exceeding our estimate, notwithstanding the fact that we may still be under the cost of nursing home care. Totally irrational.

Finally, we feel that the 90-day clock is anything but a 90-day clock. Somewhere around the end of 90 days, we have learned to expect the phone call. It isn't a written request for information; it is always verbal. The request may be for information that is diffi-

cult or impossible to gather in a short period of time. You clearly get the feeling that your waiver request is teetering on the brink, and if you don't make certain concessions in responding, your waiver will be denied.

Now, you have already invested perhaps 6 or 9 months of staff effort and community resources in getting ready to put the waiver in place, and ultimately you concede or withdraw your waiver request. Going eyeball-to-eyeball with the telephone is very unsettling in an area as important as this has become to us.

I would be happy to take any questions you have in general or in specific about North Carolina's experiences, but I think the States that follow will have sufficient examples. Thank you.

[Ms. Matula's prepared statement follows:]

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TESTIMONY OF
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FOR THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE

HEARING ON THE MEDICAID HOME AND COMMUNITY-BASED
SERVICES WAIVER PROGRAM

June 25, 1985

Mr. Chairman, members of the subcommittee, good morning. I am Barbara D. Matula, director of medical assistance for the state of North Carolina. I am also currently serving as chairperson of the State Medicaid Directors' Association of the American Public Welfare Association. I come before you today to offer the states' thoughts and comments regarding the home and community-based services waiver program--also known as the 2176 waiver program.

The states have learned a great deal since the passage of the Omnibus Budget Reconciliation Act of 1981 which enabled us to pursue home and community-based services as an alternative to institutional care. As you know, the program was established as part of an overall package of changes aimed at providing states more flexibility, in the face of significant reduction in federal financial participation. As of May 15 of this year, 46 states had received approval for 75 waivers to provide home and community-based services to the aged, mentally retarded, and mentally ill. Another 19 "model" waivers have been approved to provide care in the home for individuals who would otherwise have had to remain in an acute care institution. While most of these waivers began by covering only a relatively small number of individuals, it has been the states' intent to expand, if necessary, as more knowledge has been acquired on how to implement and operate home and community-based service systems. The great merit of the waiver program as established in law has been that it provides the states with an avenue to start moving away from

the bias to institutionalize people that existed in Medicaid prior to OBRA. While few of us expected any wholesale change in the structure of the program, we did believe that the waivers would be a first and very important step in providing states with the ability to bring about more of a balance between institutional care and the underdeveloped community care system. Before the waivers, states were locked into statutory requirements that precluded almost any care provided in the community. For this reason, we have actively supported and pursued the opportunities the waiver authority has presented.

Unfortunately, the waiver program has not lived up to these expectations. The administration's implementation of the program has deviated from congressional intent and thwarted states' plans to develop home and community-based care. The requirements HHS has developed as outlined in the final waiver program rules are more likely to deter, rather than encourage states, to seek waivers. These requirements and the defacto policies that preceded them supposedly were established to ensure that the program does not cost additional money. In fact, however, they have led to an unnecessary waste of state and federal effort. States have had to produce excessive assurances and documentation to receive waivers, with the final rules calling for even more data and substantiation. Somewhere along the way the concept of state flexibility has been lost.

Before outlining our specific problems with the way the waiver program is currently administered, I would like to make one thing clear. The states are in total support of the concept

of budget neutrality as it relates to this program. As the administrators of Medicaid, we would be derelict in our duty if we were not serving the needs of our clients in as cost-effective manner as possible. The argument has been made by some that, left to our own devices, the states would massively expand the program by providing care to thousands who currently do not meet the eligibility criteria. Anyone who believes this assertion has not examined the financial situation of states lately, or had to defend a Medicaid budget to a state legislature. Even if "budget neutrality" were not spelled out in the statute, the states would support such a policy because of the realities we have to face today.

Much of the controversy now surrounding the waiver program is related to how budget neutrality is monitored and enforced. The states, as I have already said, agree with the concept. We have strong arguments, however, with the administration's method of implementing it. We believe HHS and OMB have gone far beyond congressional intent. Indeed, they have gone so far that a good argument can now be made that a state would be better off by not pursuing home and community-based services as an alternative, and instead continue to build expensive nursing home beds and filling them with people who could be better served in the community.

Let me describe the major problems with the administration's current waiver policy.

First, the cost formula used to evaluate waiver requests rewards states that build nursing home beds and penalizes states that have controlled bed growth. In order to evaluate a waiver request, a comparison is made between the average cost for care estimated under the waiver and the average cost of care estimated if no waiver existed. This is a reasonable test and is called for in the statute. The problem is that in estimating what the population in need of long-term care services would be in lieu of the waiver, HCFA requires that states submit documentation on the number of beds that would be built if no waiver were granted. The documentation must be obtained from the certificate-of-need program in the state or, if such a program no longer exists, other "convincing data" on bed growth must be provided.

Using "number of beds to be built" as a surrogate measure of the population in need is a poor choice, at best. Not only does this measure fail to assess the need for care, it may do the exact opposite. If a state, in the interest of fiscal restraint, has limited, or put an outright freeze on, the nursing home beds it will allow built, it will not score well on this measure, even though the limit or freeze has increased the need for home or community care. At the same time, a state that has not controlled the building of beds would be able to document more growth, and thus receive a waiver, despite probably having less need for one. The final rules, therefore, reward states for not controlling the growth of nursing home beds and penalize states that do--the very states that have the most need for alternative services.

This perverse result is clearly not the intent of the statute. Rather than discouraging states from controlling bed growth, the waiver authority was aimed at giving states a method to slow or stop bed growth while providing a more appropriate alternative at home or in the community. What incentive is there for states to control nursing home growth, if in doing so they limit their opportunity to develop desirable alternative forms of providing long-term care?

Second, the final rule places a limit on total expenditures for home and community-based services under the waiver, a limit which imposes an unwarranted burden on the states and has no basis in the statute. The law clearly says that in order to receive a waiver a state must show that the average per capita expenditure on medical assistance in any fiscal year for individuals covered by waiver services does not exceed the average per capita expenditure if the waiver had not been in effect. States are required to submit with the waiver request estimates of these figures, and a waiver is not granted until HCFA agrees with the estimates. This is all reasonable.

However, the final rule requires states to provide assurances on an annual basis that the total expenditure for home and community-based services will not exceed the amount estimated. Federal financial participation (FFP) is to be withheld if a state exceeds its estimate, and a state may have its waiver terminated as well. We strongly object to this leap beyond the requirements of the statute. The purpose of the waiver is to provide alternative services at an average cost that is

less than or equal to the average cost of institutional care. According to HHS' interpretation of the law, a state could provide services in the community at an average cost below that for institutional care but above the estimated average cost for community care and still be penalized under this criterion. This places the states alone at risk. In every other aspect of the Medicaid program, the financial responsibility and risks are shared by the federal government and the states. If a state has estimated the cost of the program in good faith, and HCFA has agreed with this estimate, the state should not have to bear the entire financial burden, particularly if the intent of the statute (i.e., average community expenditures are to be lower than average institutional expenditures) has been met.

Third, the administrative handling of waiver requests, particularly the use of the 90-day clock for approval, has been so inconsistent that it has become a deterrent for states that may want to apply for a waiver. The final rule clarifies much of the policy HCFA will follow in approving waivers, but until now the requirements states had to meet to receive a waiver were in constant flux. Even with the final rule, some issues remain unresolved, the most notable being how the 90-day limit on a decision by HHS is to be implemented. To date the 90-day time-period has been suspended whenever HCFA has requested additional information from a state to document its waiver request. While this is reasonable for one or two additional requests, it becomes patently absurd when a state has to wait between 6 months and

one year to receive approval, as some have. The longer it takes to acquire a waiver, and the more a state has committed in terms of staff resources in establishing a waiver program, the more the state has no choice but to conform with requests from HCFA. For the approval process to be equitable, there needs to be a real time limit; one that works. The states do not mind answering additional questions, but such requests for more information should be restricted to one or, at most, two times.

A related problem states have faced with the 90-day limit is that until day 88 or 89 no additional information is exchanged between HCFA and the state, and then suddenly a telephone request for a significant amount of new data is made. States have been told that unless they supply the information by day 90, their waiver requests will be denied. Such a manipulative and deceitful practice is certainly not required by the law and has no place in the federal/state partnership within which Medicaid is administered. Incidents of this sort do great damage to the working relationship between the federal and state governments and further undermine cooperative efforts like the waiver program.

Thank you for inviting me to testify today. The state representatives who will follow me have more specific experiences to share with you. I would be happy to answer any questions you might have.

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Mr. WAXMAN. We are going to hold the questions until we hear from all three of you. We appreciate your testimony.

STATEMENT OF RICHARD C. LADD

Mr. WAXMAN. Mr. Ladd.

Mr. LADD. Thank you.

One of the largest problems the States are facing today is long-term care, especially with the elderly. They are a fast-growing segment of our population and the inflation rate in long-term care has generally exceeded other services the State purchases. A combination of those two factors, we think, can lead to the point where it may become impossible at some future point, maybe not too far away, to support this.

When you passed 2176 of the 1981 Reconciliation Act—better known as Community Home-Based Care Waivers—we think you took the first step toward the rational solution of these problems in long-term care. While in some respects, home and community-based waivers have been a Band-Aid approach to the problem, they have been very popular and very effective. The last count, 47 States had entered into this program in some degree. Some States have gone very large into the program, some States have done small demonstrations.

Unfortunately for the 14 years previous to 1981, the Federal laws and regulations gave great incentives for institutionalization. In effect, our national policy in long-term care has been strongly biased toward placing the Nation's elderly in nursing homes when they can no longer function independently.

In Oregon, as in other States, this policy caused a tremendous growth in nursing home population along with only a slight growth in our community alternatives to nursing home facilities. For example, during the period 1974 to 1979, Oregon saw an increase of 32 percent in the Medicaid nursing home population. During this same period of time, we experienced only a growth of 16 percent in our elderly population above age 65. So Medicaid nursing homes were growing at about twice the rate of those who use them the most, the age 65-plus population.

During this same time, our community-based alternatives grew at about a 10 percent rate. What this meant was that we had many more services available in the nursing home than we had in the alternatives, and people who needed those services, both public and private, often had to go to nursing facilities.

My wife's grandmother, for example, who lived her entire 96 years in a farming community in eastern Oregon, had no other choice but a nursing home for the last 2 years of her life, even though she had minimal medical problems. Her major problems were being able to function on a day-to-day basis.

Home community-based waivers took these incentives away. They put community on an equal par with nursing facilities. Oregon received the first waiver. In the 3.5 years we have had that waiver, we effected a 6-percent reduction in our nursing home population and a 45-percent increase in our community-based alternatives. Because those alternatives are generally less expensive than

nursing facility care, we estimate that we saved the Federal Government approximately \$12 million during that 3.5-year period.

Unfortunately, the major step forward taken by you in passing home and community care waivers has been greatly slowed by what, in my opinion, can only be termed a bureaucratic mess. We started our renewal of the waiver last summer. It took us 8 months, five trips from the State of Oregon to back here in Baltimore and at least a 3-foot high stack of documentation before we were able to get a renewal of our waiver in February. Even so, we can consider ourselves fortunate to have the waiver approval before the Health Care Financing Administration filed their administrative rules on March 13.

We did, however, have to separate our mentally retarded waiver from our elderly waiver, and that was only approved a couple weeks ago. The March 13 rules require a very long list of assurances on how waivers will be administered by the States. These assurances limit the flexibility States need to operate effective and efficient waivers. For example, most States now have a preadmissions screening program that assesses applicants to nursing facilities and tries to place them in the environment that allows them to function with the maximum degree of independence. We call that deflection or diversion from nursing facility care back to the community.

The Federal Government, in the March 13 regulations, require States to specify in advance of waiver approval where these individuals will be coming from, homes or communities or what location, and how many will be coming from each location. Since presumably we will be held to these very tenuous advanced estimates, it is entirely possible that we could lose because we have exceeded those estimates: not being able to serve under the waiver people from a certain segment we underestimated. We may be in a position not to be able to serve people in the hospitals, for example.

Also from the mentally retarded side, there is a provision in the March 13 regulation, that we must give assurances that we will not file for Federal reimbursement educational/vocational programs. These programs have always been in our ICF/MR Program as a requirement. In the waivers they do not define them. The Department of Labor, however, defines vocational education—I should say adult activities centers—as therapeutic, but HCFA will not use that regulation.

But by far, the largest problem with the March 13 regulations is the limit on the number of people that can be served under a waiver. While this limit involves some quite complicated mathematics, it is based upon the number of nursing home beds available, the number of nursing home beds that are in your certificates of need process, and the number of people that you have on a waiting list. This regulation has the effect of stopping waivers in their tracks.

In Oregon, for example, we have reduced the Medicaid nursing home population by 6 percent. This has caused an extremely low growth rate of nursing home beds in Oregon, only a couple hundred in the last 4 years. It has simply eliminated our waiting list. We have only about 3 nursing homes out of the 200 in Oregon that now have waiting lists.

Our occupancy level has dropped from over 95 percent to under 90 percent. This means that the number of people on waivers will essentially be stable, with no growth allowed unless we justify such growth by building more nursing home beds and then keeping them empty. This is ludicrous from our point of view.

With an average annual increase of 3.1 percent for Oregon's elderly over age 75, and with our community-based essentially at the maximum allowed under the March 13 regulations, Oregon is now back to where we started. The incentives have now shifted back to the nursing facilities because of the March 13 regulations. Our community-based population will remain fixed, and the increase of those needing long-term care in the future will primarily be served in their facilities.

Thank you.

[Testimony resumes on p. 236.]

[Mr. Ladd's prepared statement follows:]

Richard Ladd, Administrator
STATE OF OREGON
SENIOR SERVICES DIVISION

Mr. Chairman:

I am submitting this testimony subsequent to a verbal presentation which I made to the committee on June 25, 1985. This testimony goes into more detail and it deals with items which are more of a technical nature than those which I provided verbally. It also deals more specifically with the two problem areas around which you had solicited testimony on June 25. Those areas, as I understand it, are:

1. The problems the states have had in working with the Health Care Financing Administration in implementing the waivers; and
2. Concerns we have with the Health Care Financing Administration's March 13, 1985 regulations.

My testimony deals with these two subjects in the order mentioned above. In addition to that, I will present some specific proposals regarding the action I feel Congress should take in the long and short run to deal with the long-term care of this country's aged and disabled population which is at risk of institutionalization.

I. Problems in Implementing the Waiver

Perhaps, Mr. Chairman, I can best illustrate the problems Oregon has had implementing its waivers by reviewing the sequence of events which has occurred over the past year as our state attempted to renew its first home and community based care waiver. Oregon was the first state granted a waiver under Section 1915(c) of the act. We submitted our

first application for a comprehensive waiver shortly after Section 2176 of the Omnibus Reconciliation Bill was passed. That application was quickly approved by the Health Care Financing Administration. Our waiver served aged, blind and disabled as well as mentally retarded and mentally ill individuals. Prior to obtaining approval for the waiver, Oregon had conducted several years of research in cooperation with the Health Care Financing Administration and the Administration on Aging on the subject of long-term care and how to obtain a balance between nursing homes and community based services that would best meet the needs of the elderly and the disabled.

The waiver had been very successful in nearly all respects as far as we could determine. During these first three years of our initial waiver, we reduced the number of individual Medicaid funded nursing home recipients from 13,188 to 12,387. Had the growth patterns which preceded the waiver period continued, we would have served 15,243 individuals in nursing homes. We accomplished this by diverting from nursing home care approximately 4,200 individuals and by relocating approximately 3,110 individuals from nursing facility placements to community settings. Although it was not the intent of the waivers to save state and federal money, we were able to accomplish substantial savings (about \$7.5 million) in federal dollars (and 12 million total dollars) during those three years.

We were, therefore, somewhat surprised, when in the Spring of 1984, HCFA's Region X office encouraged us to submit our application for renewal of our waiver as early as possible. We were told that many

questions were being raised about the effectiveness of the waivers nationally by HCFA's Central Office, and by the Office of Management and Budget. Taking heed of this advice, we developed an application for renewal of our waiver and submitted it to the Health Care Financing Administration on June 1, 1984, nearly seven months before our first waiver was due to expire. Our renewal application made only minor changes in some of the services which were described in the initial approved waiver. Therefore, we expected a pro-forma approval of our renewal request as, we believe, is contemplated in the law.

We had also heard a rumor that the Health Care Financing Administration was developing a draft set of regulations pertaining to waivers which would make application perceivers for waivers much more difficult. On June 4, 1984, Senator Packwood's office wrote Carolyn Davis, the administrator of Health Care Financing Administration asking for a copy of any such draft regulations. Those draft regulations were, as far as we know, never supplied to him although we now know that they were in the process of being developed.

Toward the end of July of 1984, we began to hear some rather disquieting rumors from the state of Georgia about problems that state was facing in obtaining a renewal of its initial waiver. Although the state of Georgia had submitted its original Home and Community Based Care Waiver request subsequent to the time Oregon had done so, the Georgia request had been approved retroactively. Therefore, Georgia was about two months ahead of Oregon in going through the process required to obtain a renewal of its waiver. We heard, for instance, that the state of

Georgia had been asked to supply data regarding the cost-effectiveness of its waivers, which took into consideration such non-Medicaid programs as Food Stamps and Supplemental Security Income. Georgia had been supplied an interrogatory several pages long by the Health Care Financing Administration requesting mountains of documentation. The Health Care Financing Administration, we found, took the position that even though Georgia had requested a renewal of an existing waiver, HCFA was going to consider it a new waiver because of some changes in the population served and the services being offered by that state.

Because of the concerns we knew which were being raised about Georgia's renewal package, our staff put together a presentation package for the Health Care Financing Administration dealing with questions we felt HCFA might raise regarding our own pending renewal application. Our data quite clearly showed HCFA that Oregon's waiver had been cost-effective even after taking into account expenditures for the food stamp program and SSI programs. On August 17, 1984, I personally traveled to Baltimore along with my deputy, Jim Wilson, and Jan Curry, the Deputy Administrator of our Mental Health Division. Our purpose was to meet with HCFA officials in order to present our data to them and other officials of the Department of Health and Human Services. We met with Dr. Henry Dismaris and with Robert Wren of HCFA. Although we were courteously received by them, when we asked them what kinds of questions HCFA would be raising with respect to Oregon's waiver, we were met by silence. However, on the day we returned from Baltimore (August 20, 1984), we found a ten-page list of questions signed by an official of the HCFA Regional Office in Seattle. Those questions asked for large

numbers of details regarding our existing waiver, as well as numerous assurances regarding our planned 85-87 waiver. Their letter informed us that our waiver would be treated by HCFA as a new waiver, not renewal of an existing waiver, because of the minor changes in services we had requested in the renewal package.

The significance of treating a waiver as a new waiver instead of a renewal of a waiver is very important, Mr. Chairman. If a waiver is treated as a renewal of an existing waiver, the Secretary has 90 days to consider the renewal and either accept or reject it. However, if the waiver can be treated as a new waiver, the Secretary is allowed to ask whatever questions he or she wishes, within an initial 90-day period. The state then has to supply answers satisfactory to the Secretary regarding whatever questions the Secretary might raise. The Secretary, after receiving answers to those questions, has an additional 90 days to make a decision. For Oregon, this meant that HCFA was able to subject our staff to an additional 90 days of questioning and requests for documentation than we had expected. To find the answers to those questions and the requested documentation required hundreds of man hours. Most other business in our office came to a standstill for several months while nearly all of our available staff worked, sometimes until 2:00 or 3:00 o'clock in the morning, dealing with various requests from HCFA officials, many of which came over the telephone, each time with the implication that if the information were not supplied, our waiver would not be renewed.

On August 29, 1984, I, along with my deputy, and Leo Hegstrom, the Director of Oregon's Department of Human Resources, met in Salem, Oregon, with David Kleinburg of the Office of Management and Budget. He was in Oregon at the time on other business. Mr. Kleinburg only managed to confirm our worst fears about the Office of Management and Budget's stance regarding Home and Community Based Waivers. He told us, among other things, that the Office of Management and Budget did not want to see waivers renewed which served populations in the community larger than the population the states had been serving prior to the time that Section 2176 was passed. He left it quite clear that he and Mr. Stockman were not happy with the most states' performance on Home and Community Based Care Waivers.

On September 18, 1984, we placed in the mail our answers to HCFA's ten pages of interrogatory. We also agreed to separate that portion of our waiver dealing with the mentally retarded population out from the portion dealing with the rest of the populations (the elderly and disabled). By doing so, we felt that we would enhance chances of approval of the waiver dealing with the elderly and disabled.

On October 5, 1984, after having taken another trip at the end of September to Washington, D.C., to meet with congressional staffers, we were informed by Senator Packwood's office that Oregon would be granted a 45-day extension to its initial waiver. This was actually a mixed blessing, because it gave the Health Care Financing Administration an additional 45 days to request more documentation and use up more staff time. It also meant that the several thousand individuals in Oregon

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receiving waived services would have to wait 45 days more to know for certain if federal funding would be available to continue services to them. On October 10-12, I attended a conference in Santa Fe, New Mexico, of state agency personnel dealing with waivers from around the United States. At that time, I finally obtained a copy of the draft regulations pertaining to the waivers which the Health Care Financing Administration had been working on for several months. Those draft regulations differed very little from the ones that ended up being published on March 13, 1985. After reviewing those regulations, it became clear that Oregon was being requested to supply documentation which would later be required in the final March 13, 1985 regulations. In other words, Oregon was being required to comply with regulations which had not yet been published.

On October 17, 1984, I, Mr. Wilson and Mr. Leo Hegstrom, the Director of Oregon's Department of Human Resources, went to Washington, DC, and met personally with Carolyn Davis, the Administrator of the Health Care Financing Administration, and some of her staff. Our purpose was to determine what further steps needed to be taken by Oregon to obtain approval of its "new" waiver. At this time, we were presented with a new list of conditions that Oregon would have to meet, one of which was to place a limit on the number of individuals who would be served along with additional request for documentation. Also, we were asked to totally rewrite our waiver application in spite of the fact that we had sent several pounds of documentation supporting each of the sections in our June 1 waiver application document. Because we had so much time

invested in the waiver and because it is so essential to achieving a balance in our long-term care system, we acquiesced.

On October 29, 1984, Mr. Hegstrom, Mr. Wilson, and I met with Joseph Anderson, the Region X director of the Health Care Financing Administration in Portland. At that time, we were again told flatly that the state of Oregon would be expected to adhere to a limit on the number of persons served through the 85-87 waiver.

On November 14, 1984, my deputy, Mr. Wilson and other Senior Services Division staff traveled to Seattle, Washington and reached what they thought was an agreement with Region X HCFA staff on the numbers of individuals HCFA would allow to be served under the waiver as well as the growth rates in the community and nursing home populations which would be allowable. From that date, until the waiver was due to expire on December 21, 1984, our staff were in almost continuous contact with the Region by telephone, making several revisions to the wording on various pages of the waiver document. For instance, on December 19, 1984, we received a call from the Region X HCFA office and were informed that HCFA wanted additional assurances, in writing, that no financial participation would be claimed by the state on community based services for situations where a spouse was the provider of the service. We were also asked to withdraw the answers to any questions which we had provided in response to the Region's ten-page letter of August 20, 1984 and instead, to incorporate those answers in our waiver document. This meant we once again had to rework most of the waiver document. By this time, some pages in the waiver had been rewritten three to four times.

Then, during the first week of January, HCFA requested that I again travel to Baltimore and reach another "final" agreement on the numbers of persons who would be served in the 85-87 waiver. At that time, Mr. Robert Wren literally dictated the numbers which would be acceptable to HCFA on a napkin over lunch at a Baltimore restaurant. Those numbers were lower than the ones which had been agreed upon with the Region in November.

Finally, after one additional phone call from the Region relaying some questions which we were told came from the Office of Management and Budget (those questions demonstrated a complete lack of understanding of the waiver and we refused to answer them and complained to Senator Packwood's office) we received a letter on February 6, granting us a waiver retroactively from December 22, 1984 to December 21, 1987.

At this point, you are probably asking yourself why the state made so many concessions. The main reason for this is that, at least in the state of Oregon, the waiver is no longer in the experimental stage. Our waiver was in operation statewide serving over 5,000 individuals. If funding for the waiver had been lost, our nursing homes would have immediately filled and there would have been considerable demand to build more nursing home beds. We simply could not afford to have that sort of situation occur either fiscally or in terms of the human suffering. Being over that kind of barrel, we found ourselves making concessions inch-by-inch as each new demand was made.

The period of June 1, 1984 through January 31, 1985 was one of almost continuous harassment by the Health Care Financing Administration and the Office of Management and Budget. The waiver document which was finally approved was considerably different from the one we had submitted.

II. Concerns With March 13, 1985 Regulations

It is Oregon's position that complying with HCFA's regulations of March 13, 1985 will put the states back in a position where it is fiscally more attractive to place individuals in nursing homes than to place them in community based care. The regulations demonstrate a fundamental lack of understanding of how long-term care systems operate in a state.

The first major problem in the regulations is that they isolate and limit the population which will be served under the waivers and ignore their relationship to Medicaid eligible individuals in nursing homes who are being served at costs of two to three times the cost of like individuals in community settings. The wording in the new regulations found in 42 CFR 441.302 says, "The agency's actual total expenditures for home and community based services under the waiver and its claim for FFP in expenditures for the services will not exceed the approved estimates for those services as expressed as the product of $C \times D$ in the supporting documentation required...." That regulation refers to a formula in which C equals the estimated number of individuals who would require home and community based services under the waiver and D equals

the estimated annual Medicaid expenditures per individual. The regulations go on to say if the product of C X D is exceeded, the Health Care Financing Administrator can terminate the waiver. This, we presume, could occur even if the state's expenditures were lower than what they would have been had the individuals served under the waiver been served in nursing homes.

The regulations make it clear that states cannot exceed their estimates. This puts the states in the position of trying to guess, three years in advance, how many people will actually be served under the waivers and then rigidly adhering to whatever estimates it has made whether adherence to those estimates make sense or not.

When Congress passed Section 1915(c) of the Social Security Act, we believe its concern was that aggregate expenditures under the waiver did not exceed those which would have occurred in the absence of the waiver. In our extensive conversations with congressional staff who developed Section 1915(c), we found no evidence that the intent of the waivers was simply to save money. The intent was that the waiver would not cause aggregate expenditures under the state's medical program to grow any more than they would have, had the waivers not been in place.

Another basic problem with the March 13 regulations, one which demonstrates HCFA's lack of understanding of how a long-term care system operates, is found in the documentation requirements of 42 CFR 441.303(f). That regulations says, "States must. . .show the number of beds in Medicaid SNF's and ICF's. . .and evidence of the need for

additional bed capacity in the absence of the waiver. States which propose a waiver population which would exceed the capacity of presently certified beds must produce viable certificates of need and other documentation that beds would actually be built and certified absent the waiver."

This regulation is a virtual Catch-22 because it limits the waiver population to the number of available certified beds in nursing homes. Estimates exceeding certified bed capacity will be found "unreasonable" by HCFA. We have found, in our several years of operating a long-term care system, that we must serve 2.6 individuals in the community in order to reduce the nursing facility beds paid for by Medicaid by one. This is simply a function of how the long-term care system operates. We cannot prevent qualified persons from being served in nursing facilities and since an empty nursing home bed creates a strong attraction for additional private and public clients, we must divert or relocate approximately five individuals to serve two fewer individuals with like impairment levels in a nursing home bed. This expansion can be accomplished using fewer federal dollars than would have been expended on nursing home beds for those individuals whose impairment levels would allow them to be placed in nursing homes because the cost of the community bed is about one-third the cost of the nursing home bed.

The regulations' requirements for estimating how many individuals the state will be able to serve in a community setting also make little sense. The preamble to the regulations say, "In developing the estimates of utilization...the state must continue to use actual data on

nursing home cost and utilization based on cost and utilization of community based services for the most recent year before the waiver takes place." Again, the regulations assume a one-to-one ratio of persons in the community to persons in nursing home beds. They seem to be premised on the theory that a nursing home bed must be kept available for each person on waivers in the community.

Any state which has been successful in controlling the utilization of long-term care institutionalization will suffer because of these regulations. In Oregon, between October 1980 and October 1983, nursing home beds increased by 2.1% (from 14,938 to 15,256). This expansion did not keep up with the population increase during the same period of time for the population at risk (age 75 and above), which over the same period of time was 10.7%. Oregon nursing home beds per thousand individuals age 75 and over dropped from 124 in October 1980 to 114 in October 1983, reflecting a reduction in occupancy rates from 92% to 90%. Oregon has achieved success in controlling the utilization of nursing facilities, but has done so by expanding community resources. We do not have nursing facility beds available for all people who are in community settings. To have them available would be expensive and unneeded. HCFA's methods of assessing our waivers seem to transmit a message to the states that if they want to expand the number of persons in community based waivers, they should go out and see that more nursing home beds are built. They thus penalize the states which have effectively reduced nursing home populations.

Another significant problem with the waiver regulations is that the waivers may be terminated if the states' total expenditures for any one of the three years of the waiver exceed the estimates which the state made for each of the three years of the waiver. This puts some states in a peculiar situation. It is possible, especially when one considers the regulations' requirement that states separate out waivers dealing with the aged, blind, and disabled from those dealing with the mentally retarded, that a state might have to spend more during one year of the waiver to develop community resources than it would have cost to keep the population institutionalized, yet could achieve significant savings in subsequent years of the waiver. In spite of that, a state must keep its expenditures below its estimates in each of the three years of the waiver or face termination of the waiver.

A matter of great concern to our Mental Health Division, which just recently received approval of a very scaled down waiver for the mentally retarded, is that states are required to provide assurances that payments will not be made for educational or vocational services, although HCFA has developed no definitions of such services. That, in and of itself, is a problem, but HCFA has exacerbated that situation with respect to Oregon by refusing to allow the state to define these services. Nor will HCFA allow Oregon to use other federal agency definitions, such as those of the Department of Labor.

In the preamble to its March 13 regulations, HCFA stated: "We do not believe that pre-vocational and vocational training and educational activities are normally furnished as a means of avoiding

institutionalization," even though they offer no data in support of this belief, while data exists from state and local sources (see attachment to a statement provided the committee by Marilee Trapp from the United Cerebral Palsy Association of Pittsburgh), indicating that such services are effective in preventing institutionalization.

We have a number of problems with several documentation requirements in the regulations which we consider unduly burdensome. For instance, in 42 CFR 441.303(f)(4), the states are required to provide specific identification of the number of clients who will be relocated or in other words deinstitutionalized as compared to those who will be diverted or, in HCFA's parlance, "deflected" from nursing homes. In other words, those who could qualify for nursing home care, but do not end up in a nursing home because they have been placed in a community setting. For those clients who are diverted or deflected, the statements specify exactly where those clients will be coming from and how many will come from each situation or location. This regulation is almost impossible to comply with and it puts the states in a position of making estimates about events which will occur three years or more in advance of when those estimates are made and it will be extremely difficult to "guess" very accurately that far in advance.

We object to the very strict interpretation in the regulations of what constitutes a "new" waiver. The regulations legitimize those actions which the Secretary had taken with respect to our state and several others prior to their March 13 publication. They gave the Secretary the authority to redesignate existing waivers as "new" even when minor

changes had been made from the state's previous waiver. The net effect of this is that the Secretary can then impose a myriad of extraneous requirements on the states every three years.

The above actions will be especially onerous when combined with the provision in 42 CFR 441.304(g) which says that after September 9, 1985, the Secretary will not allow funding for a new waiver until (as is stated in the preamble to the regulations) ". . . all issues are resolved and we are sure that the waiver program will be operated in accordance with applicable regulations." This means that the Secretary has placed herself in a position "officially" to convert even functioning and currently approved waivers into "new" waivers, and then to hold back funding for such "new" waivers until some level of satisfaction (the level of which is not made known to the states) is reached in HCFA and OMB. In Oregon, this will mean that in three years, thousands of Oregonians receiving services through the waivers will again live in fear that the funding for their services may evaporate while HCFA is becoming "satisfied." The difference this time will be that the March 13th regulations will not allow retroactive approval of waivers. Our state will be faced with having to shut its program down or drastically reduce it and would thereby eliminate years of gains it has made in developing a system of providers of in-home services.

III. Recommended Future Actions

I hope, Mr. Chairman, that my testimony to this point has shown that the Home and Community Based Waiver program, especially as currently

administered by HCFA and OMB, has only a slim chance, if any, of providing any kind of long-term solution to what is one of the largest social issues facing this nation today. We cannot, especially when faced with a situation where the elderly are becoming a larger segment of our population, continue to scale back the resources available to state and local governments which will allow them to care for persons at risk of institutionalization. Neither can we continue using the regulatory process to encourage the institutionalization of such individuals by forcing a medical model of care upon individuals when, more often than not, their problems are functional in nature.

I believe that the bills sponsored by Senator Bradley in the Senate and Congressman Wyden in the House represent a step forward in that they would allow Medicaid funding as an optional service for home and community based care.

Oregon recently conducted a survey of state Medicaid and Agency on Aging directors. I have attached a preliminary report of the findings of that survey. As you can see, over 93% of those who administer home and community based services in the country are dissatisfied with the present situation. It should also be noted that a majority of them feel that the Waivers should be made an optional program under Title XIX, as the Bradley/Wyden bill would allow.

However, Mr. Chairman, it should be pointed out that an option which ranks second among those surveyed is to create a completely separate title to the Social Security Act. My personal preference is that the

latter should be Congress's goal for passage within the next four to five years. I also believe that adequate funds are already available for the population presently eligible for Medicaid to meet their needs simply by lifting the regulations presently devoted to nursing home, home, health, personal care and funding for the present waiver program out of Title XIX and devoting it to the new title. I believe Oregon and other states have adequately demonstrated that when a state aggressively manages its long-term care systems, the needs of those Medicaid eligibles who are at risk of nursing home care can be met within existing resources. This cannot be accomplished by strapping the states with a limit on the number of people who will be served as HCFA mandates it in its March 13th regulations. In fact, it is very probable that a population larger than that which would fill available nursing home beds will have to be served, but they can be served when the state truly is given the flexibility to meet their needs in a non-medical and non-institutional setting.

One thing is certain, Mr. Chairman. We cannot continue the present situation as administered by HCFA. Oregon is in no position to again expend the kind of resources it had to expend to obtain its present waiver. Nor do I, personally, want to again see thousands of Oregonians receiving waived services to again live in fear that those services might be terminated because some petty bureaucrat in HCFA is not satisfied with the documentation we have sent. I urge you to take action quickly to make the waiver a permanent part of the Medicaid program as an optional service, but in the long run, a more definitive and long-range solution the problem needs to be taken by addressing it separately from the Medicaid program.

SURVEY ON
HOME AND COMMUNITY-BASED WAIVERS

The State of Oregon sent a questionnaire survey to each State Medicaid Director and to each State Aging Director regarding Home and Community-Based Waivers. The preliminary results are as follows:

A. General

- 99 surveys were sent
- 45 responses were received (45.5%)
- 34 states responded (68%)
- 27 Medicaid Directors responded
- 20 Aging Directors responded
- 12 states had both Medicaid and Aging Directors respond (two states had both Medicaid and Aging responses incorporated into one response jointly).

B. Specific

1. To the question "Are you satisfied with present situation?".
 - 2 states said yes (6.2%)
 - 32 states said no (94.1%)
2. States were asked to rank four different options to the present situation.

Option (a). Rewrite of present waiver legislation (Section 1915(c) of the Social Security Act).

- 6 respondents ranked this first.
- 12 respondents ranked this second.
- 9 respondents ranked this third.
- 14 respondents ranked this fourth.
- 4 respondents did not rank this option.

Average rank was 2.76.

Option (b). Add Home and Community-Based Waivers as an optional service under Title XIX:

- 23 respondents ranked this first.
- 10 respondents ranked this second.
- 6 respondents ranked this third.
- 3 respondents ranked this fourth.
- 3 respondents did not rank this option.

Average rank was 1.74.

Option (c). Block Grant all long-term care funding to the states:

- 7 respondents ranked this first.
- 10 respondents ranked this second.
- 10 respondents ranked this third.
- 15 respondents ranked this fourth.
- 3 respondents did not rank this option.

Average rank was 2.79.

Option (d). Create a new title to the Social Security Act which would include all long-term care funding.

- 9 respondents ranked this first.
- 11 respondents ranked this second.
- 13 respondents ranked this third.
- 10 respondents ranked this fourth.
- 2 respondents did not rank this option.

Average rank was 2.56.

A few states ranked more than one option the same. Almost half of those responding, however, choose option (b) (add Home and Community-Based Waivers as an optional service under Title XIX) as their first choice. The other three choices seem about even, with option (d) (creating a new title to the Social Security Act) slightly more popular than the other two.

Many respondents added comments that indicated they liked option (c) or (d), but were very fearful that these options would lead to reduced funding from the federal government (as has been the case with the Social Services Block Grants).

A few states indicated that option (b) was a good short-term solution, but that option (d) should be the long-term choice.

3. States were also asked if there was another option to the present waiver situation that would be attractive to them, and how they would rank that option.

- 16 respondents listed other options.
- 13 respondents ranked this other option first.
- 2 respondents ranked this other option second.
- 1 respondent ranked this other option third.

More specifically:

2 states indicated satisfaction with the present situation.

2 states indicated that moving waivers to optional services under Title XIX was desirable, but that the scope of optional services should be reduced.

- 3 states indicated that long-term care should be incorporated into either Title XX (Social Services Block Grant) or the Older Americans Act, and transferred to the Office of Human Development Services (OHDS).
 - 3 states supported a two-stage approach with either a block grant or optional service status first, with a new title for long-term care later.
 - 1 state suggested moving long-term care to Medicare.
 - 1 state suggested restricting OMB activities in long-term care.
 - 1 state supported a new title but with assurances of a wide range of services allowable.
 - 1 state suggested we communicate to HCFA our displeasure with the March 13th regulations.
 - 1 state supported any action which allowed more flexibility.
 - 1 state indicated that after a three-year waiver period, long-term care became a part of the State Title XIX plan (if proven cost effective).
4. Finally, states were asked if they would be willing to provide testimony if hearings were held on Home and Community-Based Waivers. Thirty-one (68.9%) respondents indicated they would be willing to do so.

Mr. WAXMAN. Thank you.
Ms. Kurland.

STATEMENT OF CAROL H. KURLAND

Ms. KURLAND. I am Carol H. Kurland, from the New Jersey Department of Human Services Division of Medical Assistance and Health Services.

I am what you call a frontline administrator. I am involved in the daily operations of the program. I am the one that corresponds and communicates with HCFA so I have been involved in the total process of the waivers.

Our department appreciates the opportunity of coming here today to present testimony on our experiences in these programs. We are particularly proud of John Randolph, who did a superb job in presenting his experiences.

We in New Jersey strongly endorse the law, Public Law 97-35, which initiated the waivers. It has enabled us to provide what we consider to be appropriate care to individuals to keep them home with their families and it has allowed people to choose between home care and institutional care, a choice that is usually reserved for those people with private funds, not with public funds.

State governments really want to help. However, some of the features of this law make it very difficult. Some of those features that are particularly valuable however to New Jersey are a State's ability to provide home care services to individuals who could only attain Medicare eligibility if placed in an institution because of the higher or special income cap.

Without the waiver, an incentive toward institutionalization would exist. The State's ability to consider only the individual's own resources and not the resources of his parents or his spouse is

very important. This is particularly helpful because it enables children, such as Katie Beckett, to return to families. The State's ability to provide an array of services, home services, that are normally not available under Medicaid, such as in our case, homemaker's service, which is by far the largest and most frequently used service in our elderly waiver is also important.

Our elderly and disabled waivers has served about 1,400 people since its inception in October 1983. And our experience reveals that the cost of home care equals approximately 50 percent of what it would have cost in a nursing home to a comparable group of people. When one talks about targeting population, we recently studied our population and found that the level of care is almost identical to people being served at home as those in the nursing home and we used identical criteria and assessment team and very similar assessment forms.

The savings in our developmentally disabled waiver are even more dramatic. In the first year 1,900 individuals were served by home care, eliminating the need to create institutional beds, thereby saving approximately \$14 million of Federal-State moneys, and the second year, we are looking toward a savings of \$59 million.

It is my understanding also that you are interested in Jersey's model waiver and our experience in serving several disabled children. In my written testimony I have included two examples of success stories in the model wavier. We have used it to serve children who are very much like Katie Beckett.

We have had experience with the Katie Beckett waivers, for example, in serving seven children when the model waiver wasn't in existence. We have been saving \$50,000 a month for those seven children and giving them much more appropriate care at home. We integrate private insurances with a variety of other insurances, community care, and using the informal network to its maximum.

However, the enormous value of our model waiver has been reduced by the length of time it takes for approval of new waivers and strict interpretation of regulations. Our first model waiver, for example, was approved October 1983. All 50 slots were quickly filled with a waiting list which grew to over 100 persons.

We applied for a second waiver in October 1984. Despite the fact that the second waiver was a replica of the first waiver, which received, by the way, outstanding assessment from our regional HCFA team. The second waiver was not approved until May 1985, which was almost 7 months later. We reviewed our waiting list upon the approval of this second waiver. Some of the individuals unfortunately had been institutionalized during that span of time and others had died. So we felt really let down and that we could have served these people had we received it much earlier.

One of our most serious administrative problems has been caused by HCFA's interpretation of what is a naughty word in New Jersey, the cost-sharing liability. This provision states that the individuals who are served under the special income level—that is those who are institutionally but not community eligible for Medicaid services—must contribute all income over \$356, which is New Jersey's SSI level, toward the cost of health care. This doesn't make sufficient allowance for those people who are living at a higher income level.

It also requires at times—intolerable physical and psychological disruptions—making them move to other housing, assuming other kinds of arrangements or even preventing the participation of the participants.

We are fortunate in that Gov. Thomas Kean of New Jersey requested a revision in this regulation of HCFA to allow for an additional maintenance deduction.

When this request was denied by Health and Human Services, New Jersey opted to absorb up to \$75. As you heard before, Senator Bill Bradley on June 11 introduced S. 1277, which is called the Medicaid Home and Community Based Services Improvement Act of 1985.

And I am very pleased Congressman Wyden has cosponsored this in the House. This will amend title 19. It addresses problems in the regulation such as this cost-share liability, which is such a problem in New Jersey.

Senator Bradley and Congressman Wyden have incorporated an increased maintenance deduction of \$150 into this bill mitigating the problems that we have experienced in New Jersey's waivers.

The amendment which also allows States to provide home and community based services as an optional service under Medicaid without the necessity of a waiver, which would be just wonderful.

As an optional service under the State plan, these services could be provided without regulatory control such as we have experienced under the waivers. They will be assessed annually by HCFA as all other optional services are, such as personal care services, which is an optional service.

And States could use these services within their own cost-effective limitations as defined by the law. There are other regulatory problems that we have found in the March final regulations. A primary one, as Mr. Ladd says, is the cost-effectiveness equation, which must be used with every waiver request.

This equation requires a comparison of the cost of home care to the cost of care provided in institutions, defined as nursing homes, because of the ever changing nature of home care, sicker people are coming home. The use of nursing home data in the equation does not permit the State sufficient flexibility to serve these heavier care patients at home even when it is cost effective and the choice of the patient.

We recommend more flexibility in the equation so that States which choose to do so could break away from the nursing home data and use totally hospital data to demonstrate cost effectiveness.

This is particularly true in our model waiver programs where we are finding several ill people being served at home. The regulations also, as stated, does not allow us to exceed the service costs, the estimated service costs or the numbers of people estimated in the equation.

There is no attempt to view these as estimates, as most estimates, are based upon assumptions. Without the experience of the waivers, we have no idea what the client turnover is going to be in the waiver and it is very difficult to project ahead in terms of, if the actual figures are going to equal the estimate figures. They are denied even in situations where the States are realizing dramatic cost savings.

Although we had viewed the waivers as improving our home care service-delivery system in New Jersey, and we had looked forward to this, a system which has to evolve and change as we experience the program, creating changes is very cumbersome in the waiver regulations.

Each change must be approved by a HCFA process which may take months. For example, we requested from HCFA permission to remove a pharmaceutical service because it was cumbersome administratively and because our clients were reluctant to terminate coverage from our State Drug Program.

This request took a full 90 days to be approved even though the State was using 100 percent of its States moneys to pay for the service.

One more interpretation that has been particularly troublesome to us in the 50-person model waiver program is HCFA's decision a slot may not be refilled or a person duplicated within a given program year. Therefore, if an individual, 1 of the 50, enters a nursing home or homes and is terminated from the program, the 50-person program becomes 49 until the next contract year.

It is our understanding, however, that the administration is reconsidering this decision. We certainly hope so in New Jersey. One of the reasons we are applying for a third model waiver is that six of our people have either entered nursing homes or have died and we are six less than our model 50 waiver program and unable to replace them.

[The prepared statement of Ms. Kurland follows:]

TESTIMONY OF CAROL H. KURLAND
ADMINISTRATOR, OFFICE OF HOME CARE PROGRAMS
NEW JERSEY DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Mr. Chairman and Members of the Subcommittee:

I am Carol H. Kurland, Administrator of the Office of Home Care Programs in the New Jersey Department of Human Services, Division of Medical Assistance and Health Services. My office is responsible for administering the Section 2176 Home and Community Based Services Waivers. The State of New Jersey has four approved Medicaid Waivers: two regular waivers, one for the Developmentally Disabled and one for the Elderly and Disabled; and two Model Waivers for blind or disabled children and adults.

Our Department appreciates the opportunity to provide testimony regarding our experiences in implementing these programs. We want to commend the Chairman and Subcommittee for scheduling these important hearings.

We in New Jersey strongly believe that the philosophy behind Public Law 97-35 is noteworthy. It has enabled us to provide appropriate home care to numerous individuals who would have been institutionalized at much greater public cost, away from the love and attention of families and friends. It has allowed individuals to choose between home and institutional care, a choice usually reserved for those with private funds.

Features in this law which are particularly valuable to New Jersey are:

- 1) The State's ability to provide home care services to people who are otherwise ineligible for Medicaid coverage. These individuals may only attain Medicaid eligibility if placed in an institution because of a higher or special income level above the community standard of eligibility. Without the waivers, an incentive toward institutionalization exists.
- 2) The State's ability to consider only the individual's own resources in determining Medicaid eligibility and not the resources of a parent and/or spouse. This is especially helpful in enabling children to return home to their families.
- 3) The State's ability to provide an array of home and community based services. For example, homemaker service, which is not usually covered under Title XIX, is the most frequently used service in our Elderly and Disabled Waiver.

Our Elderly and Disabled Waiver, which has served 1400 persons with only seven needed home care services since its inception in October 1983, is providing these services at approximately 50% of the cost of nursing home care to a group of persons comparable to those served in nursing homes.

The savings reflected in the Developmentally Disabled Waiver are even more dramatic. In the first year, 1900 individuals were served by home care, eliminating the need to create institutional beds, thereby saving 14 million dollars of Federal-State monies. The second year will show a savings of 59 million dollars.

It is my understanding that you are interested in New Jersey's experiences in serving severely disabled children under the 50-person Model Waiver. Two actual cases illustrate its value.

- 1) Theresa is a three year old child with a serious seizure disorder. She requires constant supervision from a trained parent or licensed nurse. In April, 1984, the mother had a second child with the same impairment. Theresa would have been institutionalized without the waiver since the mother could not manage the care of both children. The Model Waiver enabled us to provide assistance in the home five days a week, resulting in a potential savings of over \$3,000 a month and retaining the integrity of this family.
- 2) Jason, a seventeen year old, fell from a tree in April, 1983, sustaining fractures which left him quadriplegic. After his hospital rehabilitative care, Jason was discharged home to the care of his divorced father and two younger sisters. Although some free care was available from United Way, the bulk of home care: home health aide and nursing services, transportation to therapies, and counseling were provided under the Model Waiver. In November, 1984, at the age of 18, Jason became eligible for SSI and therefore for Medicaid, and no longer required the Model Waiver program. Today he is graduating from high school and will attend Rutgers University to study psychology, living on the main campus. With the help of Student Services and limited home health aide services under Medicaid, Jason will hopefully lead a future productive life.

However, the enormous value of the Model Waiver has been reduced by the length of time it takes for approval of new waivers and strict interpretations of the regulations.

Our first Model Waiver was approved October, 1983. All 50 slots were quickly filled, with a waiting list of over 100 persons. We applied for a second Model Waiver in October, 1984. Despite the fact that the second waiver was a replica of the first Model Waiver, which received an outstanding HCFA assessment, the second Model Waiver was not approved until May, 1985, almost seven months later. We reviewed our waiting list upon the approval of the second Model Waiver; some individuals had been institutionalized or had died while awaiting home care.

I will now like to quote from Page 1002 of the Federal Register, Vol. 50, No. 49, March 13, 1985, of HCFA's Final Regulations which reads "In general, we believe that Congress intended to give the States maximum flexibility in operating their waiver programs. We expect this flexibility to foster initiative and to encourage States to administer cost-effective programs that meet specific local needs."

Our contacts with other states and our own experience demonstrate that the programs are innovative, appropriate and meeting needs, well accepted by consumers and providers, and cost-effective. Yet the Regulations governing them, the interpretation of these Regulations, and the process to secure interpretation, approval, or amendment are far from the flexibility described in the Federal Register.

Our most serious administrative problem has been caused by HCFA's interpretation of the cost-sharing liability. This provision states that individuals who are served under the Special Income Level, that

is, those who are institutionally but not community eligible for Medicaid services, must contribute all income over \$345 (New Jersey's SSI level) toward the cost of health care. This regulation does not make sufficient allowance for living expenses, often requiring intolerable physical and psychological disruptions in established living patterns or preventing the participation of appropriate clients.

Governor Thomas Kean requested a revision in this regulation to allow for an additional maintenance deductible. When this request was denied by Health and Human Services, New Jersey opted to absorb up to \$75 of each individual's cost-share.

Senator Bill Bradley on June 11, 1985, introduced S-1277, which would amend Title XIX. S-1277 addresses problems in the Regulations such as the cost-share liability requirement. Senator Bradley has incorporated an increased maintenance deduction of \$150 into S-1277, mitigating the problems experienced in New Jersey's waivers. The amendment would also allow States to provide home and community-based services as an optional service under Medicaid, without the necessity of a waiver.

As an optional service under a State Plan, home and community-based services could be provided without the regulatory constraints which accompany waivers. States would be assessed annually by HCFA as they are for other optional services, such as personal care, pharmaceuticals, medical supplies, etc. States could utilize these services within cost-effective limitations similar to the waiver programs.

The Waiver Regulations require persons to meet the same medical necessity requirements under the waiver as when entering the nursing home. This means that intervention under the waiver may be too late to prevent institutionalization for many individuals. In his Bill, Senator Bradley modifies the language to "persons who are at risk of requiring long term care."

Senator Bradley's response to the needs of persons who require service in our waiver programs is much appreciated by the State.

In addition to these major policy issues, there are several other regulatory problems evidenced in the April, 1985 Final Regulations. A primary one is the cost-effectiveness equation, which must be used in each waiver request. This equation requires the comparison of the cost of home care to the cost of care provided in institutions, defined as nursing homes. Because of the ever-changing nature of home care, sicker, more disabled and needier individuals return home from hospitals. The use of nursing home data in the equation does not permit the states sufficient flexibility to serve these heavier care individuals at home even when it is more cost-effective and the choice of the patient. We recommend more flexibility in this equation so that states which choose to do so, may break away from nursing home data and use hospital data to demonstrate cost-effectiveness, and appropriate care, particularly in the Model Waivers.

The Regulation also will not allow states to exceed the service costs or numbers of persons estimated in the equation. These estimates in the equation are based on assumptions made before experience with such factors as client turnover. The Final Regulations penalize states with termination of waivers or federal

funds if actual figures exceed estimates, even in situations where states are realizing dramatic cost-savings.

The link to nursing homes is reflected in another section of the Regulations. Although residing in the community and receiving home care services, New Jersey's special income level clients served under the waivers are considered institutionalized. Under the institutional regulation (42 CFR 435.722(c)), they must receive a full calendar month of service before the State can claim federal funds. For example, an individual could be approved for the waiver program on June 6th but must wait until July 1st to receive services, unless the state chooses to absorb the total cost of care for the partial month of service. New Jersey feels that the application of this institutional regulation to community individuals is a real disincentive for certain states to remain in this program.

Finally, the Final Regulations appear to require the provision of all Medicaid State Plan Services to waiver recipients, as contrasted with the limited service package provided in New Jersey's Elderly and Disabled Waiver; this will be less cost-effective and will be more difficult to administer, especially within fixed service cost controls. This change from the Interim Regulations will impact adversely on our program.

Although we had viewed the waivers as a method of improving the home care service delivery system in New Jersey, a system which, of necessity, must evolve and change to meet the needs of clients, community and state, creating changes is very cumbersome in the waiver

process. Each change must be approved by HCFA, a process which takes months.

For example, we requested permission from HCFA to remove pharmaceuticals as a covered service in our Elderly waiver because it was administratively cumbersome and clients were reluctant to terminate coverage in our State drug program. This request took a full 90 days to be approved, even though the State was using 100% State monies to resolve the situation.

The Regulations also do not allow an appeal of the denial of an amendment nor an appeal of an unacceptable interpretation.

An interpretation which has been particularly troublesome in the 50-person Model Waiver Program is HCFA's decision that a slot may not be refilled or duplicated within a given program year. Therefore, if an individual enters a nursing home or hospital, and is terminated from program, the 50-person waiver may serve only 49 persons the rest of the year. It is our understanding that the Administration is reconsidering this decision.

In summary, we applaud the objectives of Public Law 97-35. Our experiences have shown that waiver type programs are essential and do meet the needs of New Jersey residents. We feel, however, that the states in implementing these waivers are constrained by excessive regulations and unclear and rigid interpretations.

We, therefore, urge the introduction of Senator Bradley's Bill S-1277 into the House of Representatives. This bill would allow the states to more flexibly provide needed home and community-based services as a true alternative to institutionalization.

Mr. WAXMAN. Thank you. The rest of your statement will be included in the record.

You have given us very specific examples. These are very helpful to us. The three of you come from States, it is not by accident, where your Governors are Republican.

So this is clearly not a partisan issue. It is a bipartisan concern as to how best take care of chronically ill people who rely on Medicaid for their health care needs. It is somewhat ironic that we have an administration that, by purported philosophy, believes in restoring responsibility to the States, and argues that we shouldn't have intrusive overregulation by the Federal Government. The administration would never impose the degree of regulation on the chemical industry that they are placing on the States under 2176.

What we have here is intrusive overregulation developed by HCFA, and I believe OMB as well, that is out to destroy the very purpose Congress intended in adopting the 2176 waiver.

I have never heard of such stringent restrictions being placed on a State under Medicaid.

I would doubt very much when it comes to the question of waivers to allow States to restrict the providers whom Medicare patients may use, that the administration is giving such careful scrutiny to what the States are doing. What the administration is most interested in is, how do we spend less money on these people, as if they are not deserving of sufficient Federal support in order to get their health care needs met.

We understand that the interpretation we are getting from OMB and HCFA of the budget neutrality provision of the statute is to require the States to demonstrate that they will save money. We never intended that that would be the purpose. We wanted to require you not to spend more than otherwise, but not to require you to save money. If you can save money, God bless you. It is important to you to save money, just as it is to the Federal Government.

Can you explain how these regulations are telling you that you are supposed to save money? Ms. Matula.

Ms. MATULA. This is interesting. Back in February, we met with some HCFA officials about the restrictiveness in applying the formula.

There is nothing in the formula that will eliminate or deny your waiver. It is people who deny your waiver. And they deny it sometimes on some very subjective kinds of things, things not written down.

We were told that 75 percent of the cost of nursing home care would be the guideline, the upper limit to which a waiver would be approved, and we said, will you deny a waiver if the costs are shown to be 77 percent or 80 percent? You know, the law says the same as or less than. It doesn't say 75 percent. We were told that, and I would quote, "such waiver requests would be viewed dimly." They would take a dim view in approval. Right now, I have a waiver request that is within the 10 days of renewal in which I am being told that I am being viewed dimly because I am at about 77 percent, that my costs are too high.

Now remember these are the same costs that I will be held accountable for estimating accurately. I am told that my costs are higher than they were before. Well, yes, they are, we are learning

more, the services are becoming available and now I would like to act in an abundance of caution and I too would like to preserve my right to not exceed my estimate.

So I should come in with a higher estimate or else I am really a dummy. We will know in the next 10 days where this war of nerves will lead us.

Mr. WAXMAN. I was struck by the comment you made that you don't get written statements as much as you get telephone conversations, where some bureaucrat at the Federal level is suggesting things that sound awfully subjective.

Do we have no objective standards? Is this all a situation where bureaucrats, through the way they administer the regulations, can frustrate what Congress intended to do when we adopted the waiver?

Ms. MATULA. It is called "request for additional information."

Mr. WAXMAN. That sounds pretty sanitized, doesn't it?

Ms. MATULA. I would like to submit for the record a memo written by Harriet Fox, a consultant to the Division of Maternal and Child Health, on documentation of cost effectiveness under the 2176 waiver program in which she unemotionally and I hope detachedly—I don't know who she is—but she outlines how the waiver approval process takes place. It describes the additional information request and the timing constraints and she says some States have elected to sink or swim on the basis of a quickly revised submission.

I think that the information in here is probably less emotional than I might detail it, but I hope it is appropriate. I suspect it was paid for by HHS, so I hope they will stand by it.

Mr. WAXMAN. I think they are starting the process of refusing to pay for studies that may be critical of them.

Ms. KURLAND, you mentioned there is one issue your State was dealing with and your Governor had to intercede. What was that issue?

Ms. KURLAND. I mentioned one of our biggest problems was the cost-share liability where clients have to copay, if you will, pay for the cost of their care. The Governor attempted—made a valiant effort to change the regulations, but when that was not possible, when it was denied, our state opted to assume a portion of that cost-share, paying up to \$75 for each person who has to provide that cost-share liability. So we were not able to reverse it.

Mr. WAXMAN. Well, this testimony you have given us has been very helpful. We are going to hear in a few minutes from Carolyn Davis, from HCFA. We will be interested in how they respond to some of these concerns.

Mr. WYDEN. Thank you, Mr. Chairman.

All of you have given excellent testimony and I think we would agree on our common cause and that is to turn things around. We consider today's situation intolerable. We want to come up with an approach that can get support in both political parties to turn it around.

Senator Bradley and I have introduced one approach. I think that is the way to go. Are there other approaches we could employ that would give us a chance to take such a promising concept and really get it used in the maximum fashion? We think our bill is the

way to go but there are probably others. Could you give us suggestions to help us turn this situation around?

Mr. LADD. In our opinion, in Oregon the real problem is long-term care is more of a social functional program than a medical program.

While your bill is the way to go for the short-term, I think in the long-term, 5 or 10 years from now, that we really need a new title to the Social Security Act that recognizes that we are dealing with chronic problems here. We are talking about people who now have a broken hip who need to function with a broken hip or who now have arthritis and can't feed themselves any more.

Those are functional problems more than medical problems and we need to focus in on that instead of trying to continue with the medical model, to have everything prescribed by physicians, supervised by RN's and a long list of medical regulations.

Ms. MATULA. As you know, sir, I am very interested in finding other ways to finance these needs because I think it is a burden that will outstrip Medicaid's ability to pay, and the long-term care insurance aspects are so critical. I am hearing from the insurance industry that home care for long-term care is perhaps uninsurable, that it is an event that is uninsurable.

We need to look to see how we can develop other financing mechanisms other than taxpayer dollars, and how we can channel that to home care and not further exacerbate the institutional bias that financing mechanisms seem to favor.

Ms. KURLAND. I would like to continue to support your bill. We think in New Jersey that it would be, in terms of practicality of an operation, that it would be the easiest way to go at this point in time. We are concerned, of course, with the constant link to the institutional world, if you will, through regulations. There are some regulations that need to be addressed, I believe, even within your legislation, but we really do believe that is the way to go.

Mr. WYDEN. Let me ask this question maybe in a different way.

Could you all identify for us the specific procedural barriers, the real hoops that HCFA and OMB have imposed on you? If the three of you could just give us the key ones maybe we can use that as the real framework to look at a new approach. Why don't we start with you, Ms. Kurland, and then go down the row.

Ms. KURLAND. I think it varies with the—first of all, the cost-effectiveness of this equation, it needs tremendous analysis and I think all of us have touched upon that. We are most concerned about that.

I would say also that New Jersey has some particular problems because some of our problems are geared mainly to the special income population, and because of that we have this cost-share liability problem. We also have a problem relative to the reimbursement for the services.

The process itself is cumbersome. It drags out forever. As Ms. Matula said, the 90 days never remains 90 days, it continues on and on. And we have to repeat ourselves. We have four waivers. We had to submit assurances in separate letters verbatim on every single one of our waivers, and when I submit the fifth waiver we will have to reinvent the wheel all over again. So it takes tremen-

dous staff administrative time, unnecessary time, when we could be serving people.

Ms. MATULA. I would make it very clear in legislation that there can be no artificial limits to the numbers of people we serve, that there can be no artificial limit within the cost of the services we provide as long as it is less than the average cost of institutional care.

And I would make very clear and I would hope you would amend your bill to recognize that the data we are required to report must be available to us.

We are being told the system that we have, this massive Medicaid management information system that collects data beyond your wildest dreams is not appropriate for reporting on this tiny program, that we will probably have to put in a new system or capture all the data on a manual basis.

We now capture data on the date of payment. The 2176 waiver regulations require data captured on date of service, which means you must go back each year and revise previous annual reports in great detail in an effort to capture data that at this point in time is less than 2 percent of my program dollars.

Mr. WYDEN. Mr. Ladd.

Mr. LADD. Well, generally, the 8-month period that we went through in reviewing our elderly waiver and almost a year period in getting the mentally retarded waiver approved is one I can only term as a period of harassment. We had to assign five staff people full time in order to go through all these hoops and for the first 8 months we didn't even know what the hoops were going to be.

We didn't have the March 13 regulations. So we would finish a paper and think we had complied with all the regulations or all that HCFA wanted and then find out there was something else they wanted to look at. Compounded by the fact that the region office in Seattle often times was miscommunicating with the central office in Baltimore, and we got some very confused messages during this period of time.

Also, that was all compounded by their wanting to look at the first 2 years of the waiver according to their famous reporting forms, 371 and 372, which it took us a very long time in order to be able to give them the information that they required, because that was a new way for us of collecting data.

I understand when I talk to other States who have waivers they experienced similar problems with those forms. So it has just been a long really nightmare as far as we are concerned. So if nothing else comes out of all this except moving the waivers into an optional status, even if they are the way they are it would be a major improvement for the States. We could save a lot of taxpayer dollars in filling out forms if we can put that money into programs.

Mr. WYDEN. We will have to see if we can get our legislative counsel to write into this bill, "thou shall not harass." Certainly a lot of your suggestions are very good. One other point for our record. Our subcommittee would be interested in the results of the survey Oregon conducted on the March 13 regulations. Could you submit copies of those results to us for our record?

Mr. LADD. Yes.

Mr. WAXMAN. Would the gentleman yield?

Mr. WYDEN. I would be happy to yield to the chairman.

Mr. WAXMAN. One of the concerns I know we are going to be hearing from the administration is that the States are going to shift over to the Federal Government costs that otherwise the States would have had to bear. Also, to use a term that was used earlier today, there would be woodworking. People, God forbid, would get services who should not have gotten services because they weren't first in an institution.

How do you respond to these two criticisms as a justification for these very complicated restrictions that are placed on the States?

Mr. LADD. From Oregon's standpoint, our State funded program accounts for about 50 percent of our total client's community based care, and that program has grown.

In fact, we just finished our legislative session and were successful in getting another \$1 million for the State funded program. Of course, the community program—at the same time we reduced our nursing home population by 6 percent, which allowed that kind of growth. From our standpoint, those statements are without foundation.

Ms. MATULA. I don't think any State should apologize for moving legitimate Medicaid eligibles into a legitimate Medicaid program. After all, it is the States that have been filling this major gap in providing all of the services until the waivers came along.

There is no Federal program. This is the first acknowledgement there is a Federal responsibility. So I would encourage States to move those persons who truly require the services and are eligible into it without apology and without shame.

Ms. KURLAND. I can say in our elderly program we are providing new kinds of services, less costly, more appropriate services, to a targeted population, people who would have entered nursing homes we have no question about.

In fact, some of them are even sicker who remain at home than remain in nursing homes. With our institutional people, such as Mr. Randolph, we certainly—the beds were in process, being built, and there was no question that we are in effect giving more appropriate care and less cost to the State.

Mr. WAXMAN. Thank you very much.

Mr. Tauke.

Mr. TAUKE. Thank you, Mr. Chairman. I apologize for my absence earlier. I tried to run amendments on three hearings as well as be at this hearing.

A couple of questions. I know all of you have from time to time heard a lot of comments as we have about States living within the budgets that have been set by HCFA for these programs.

I am wondering, why is it wrong for HCFA to expect States to live within the budget estimated and provide services for the waiver population?

Ms. MATULA. I will take a shot at that.

In my \$650 million budget for services, over \$300 million of it goes to the nursing home population, whether they are in skilled nursing, ICF ICFMR. In the 2 years we have been operational in the waiver program we haven't spent but \$1.6 million altogether for home and community-based services.

In trying to keep people out of these more costly institutional services, it is the silliest, penny-wise and pound foolish argument I have ever heard, to artificially limit the number of people I can keep out of the institutions which will cost more, cost the States more and will cost the Federal Government more.

Mr. TAUKE. Anybody else?

Ms. KURLAND. The other issue is we must remain at the estimated population—within the estimated cost. So even if we could serve two for the price of one, this is not possible.

Mr. LADD. Also, we are more accountable to our State legislators for State funds than Federal funds. For every dollar of Federal funds, we are matching a dollar of State funds with that.

In Oregon, as a matter of fact, it is in the constitution, if I overspend the \$300 million I have been given I go to jail. So I am quite careful to stay within it.

Mr. TAUKE. That does provide a little extra added incentive. Do you have anything to do with the Department of Corrections?

Mr. LADD. They are a separate division within the Department of Resources.

Mr. TAUKE. What suggestions do you have to reduce the number of times HCFA must ask for additional information from applicants.

Ms. KURLAND. I would suggest if we had better guidelines as to what their expectations were up front.

Mr. TAUKE. The information needed isn't made clear at the outset.

Ms. KURLAND. Absolutely; and it differs from region to region we found out. For example, the final regulations, we have to provide an assurance and an independent audit is provided. We wrote a letter asking the timeframe for that audit, the period it covers, the kind of audit it should be. There are no guidelines. We got back a letter they are considering our requests.

In the meantime, we have provided assurances we must carry out this independent audit. So we really agreed to something we don't know what is involved.

Ms. MATULA. I think you have to limit the number of times they can come back to the well. We have had problems in the past with the kinds of questions they have asked, questions that were totally inappropriate to the Medicaid waiver.

EMOB paid a visit to my office last summer on the heels of a telephone request which I believe originated with them that in order to get approval for one of my waivers I had to give information related to how SSI expenditures would change with or without the waiver.

Well, it doesn't take a genius to know SSI checks don't come if you are in an institution, but they do come if you are not in an institution and therefore those costs would go up.

I went round and round with my little friendly visitor and asked her just what right they had to judge my waiver by this question, and the response it would get. Because the reverse again, the ludicrousness was true. If they really wanted to save SSI money they ought to put everyone in an institution and stop paying the checks. They went away, but not happy.

Mr. WAXMAN. Would the gentleman yield? Is that OMB?

Ms. MATULA. EMOB.

Mr. WAXMAN. Why were they there?

Ms. MATULA. A young lady came from EMOB to review my community based waiver program. She stayed for a day and a half. She didn't go back happy, but she did go back.

Mr. WAXMAN. She went back to OMB—

Ms. MATULA. No, EMOB.

Mr. TAUKE. Besides SSI what other—

Ms. MATULA. Food stamps and AFDC. I suggested to her in my usual pleasant fashion this is perhaps an area if they did not withdraw their requests we might have to seek legal counsel. The questions were withdrawn. We never did—we did get those in writing, I don't think. But they were withdrawn after her return to EMOB.

Mr. TAUKE. Do you consider this as harassment?

Ms. MATULA. No; I am not easily harassed, I guess. I think sometimes, though, some folks, if given the opportunity will get away with as much as you will let them get away with.

Mr. TAUKE. What was the purpose behind it? What did you gather had to be done?

Ms. MATULA. I believe EMOB is on record as being opposed to the waivers and that this was an attempt to gather information to substantiate their reasons for being opposed, which is everything except national defense will go up as soon as we turn someone loose from a nursing home.

Mr. TAUKE. Thank you very much.

Mr. WAXMAN. Mr. Walgren.

Mr. WALGREN. No questions.

Mr. WAXMAN. Let me commend the three of you and express my great appreciation to you. I think you have given us a pretty clear picture of what is going on in the administration of this waiver program.

Thank you very much for being with us.

Our final witness is Dr. Carolyn Davis, administrator of Health Care Financing Administration. She is accompanied by Mr. Robert Wren, the Director of HCFA's Office of Coverage Policy.

The subcommittee also invited Mr. John Cogan, the Associate Director for Human Resources, Veterans and Labor, the Office of Management and Budget. It is my understanding OMB played a major role in the administration of the 2176 waiver.

Unfortunately, neither Mr. Cogan, nor anyone else at OMB, is willing to appear before the subcommittee to speak on this issue. We will be submitting questions to Mr. Cogan for the record.

[Testimony resumes on p. 266.]

[The information follows:]

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June 13, 1985

Mr. John F. Cogan
Associate Director for Human Resources,
Veterans, and Labor
Office of Management and Budget
246 Old Executive Office Building
Washington, D.C. 20503

Dear Mr. Cogan:

On Tuesday, June 25, 1985, at 9:45 a.m., the Subcommittee on Health and the Environment will be conducting a hearing on the administration of the Medicaid home and community-based services waivers by the Health Care Financing Administration and the Office of Management and Budget. The Subcommittee is particularly interested in learning about the role which OMB played in the development of the regulations implementing the home and community-based services waivers, 50 Fed. Reg. 10013 (March 13, 1985), and the role which OMB now plays in the review and approval of applications for new waivers and for renewals of existing waivers.

It is my understanding that you have been personally involved in the development of the regulations and the administration of the waiver, and I would like to invite you to testify at the hearing. The Committee requires that each witness submit 100 copies of the written statement of his or her proposed testimony at least two working days prior to appearance.

Thank you for your cooperation with the Subcommittee's request.

Sincerely,

Henry A. Waxman

HENRY A. WAXMAN
Chairman, Subcommittee on
Health and Environment

HAW/asm

cc: The Honorable Edward R. Madigan

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BOB WHITTAKER, KANSAS
THOMAS J. TALKE, IOWA
DON BITTNER, PENNSYLVANIA
THOMAS J. BULLEY, JR., VIRGINIA
HOWARD C. NELSON, UTAH
MICHAEL BILIRAKIS, FLORIDA
FRED J. ECKERT, NEW YORK
JAMES T. BROYHILL, NORTH CAROLINA
(EX OFFICIO)

KAREN NELSON, STAFF DIRECTOR

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

2415 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515

PHONE (202) 225-4952

July 3, 1985

Mr. John F. Cogan
Associate Director for Human Resources,
Veterans, and Labor
Office of Management and Budget
246 Old Executive Office Building
Washington, D.C. 20503

Dear Mr. Cogan:

I regret that you were unwilling to respond to the Subcommittee's request to make yourself or a delegate available to testify before the Subcommittee on June 25, 1985, on the subject of the administration of the Medicaid home and community-based services waiver ("2176 waiver"). It is the view of the Subcommittee that public officials who implement the laws passed by the Congress ought to be accountable to Congress and the public for their actions, particularly where, as in this case, major public policy judgments are at issue.

Since the members of the Subcommittee did not have the opportunity to question you directly at the hearing, the Subcommittee would appreciate a written response to the following inquiries no later than the close of business Friday, July 12, 1985.

1.) As the hearing, Ms. Matula, the Director of the North Carolina Medicaid program, testified that, last summer, "A young lady came from EOMB to review my community-based waiver program. She stayed for a day and a half." In this regard, please

(a) State the name and position of the individual to whom Ms. Matula referred.

(b) Explain the purpose of her "review."

(c) State the legal authority under which this "review" was conducted.

(d) Submit to the Subcommittee any reports, memoranda, notes, or other documents that were prepared by OMB personnel in connection with this visit.

(e) Explain why this "review" was not conducted by the Health Care Financing Administration, to which the Congress has explicitly assigned the responsibility for the administration of the waivers.

2.) Have any OMB officials ever visited any other State agency to review or oversee the State's 2176 waiver program? If so, for each such visit, please provide:

- (a) The name and position of the OMB employees conducting the visit;
- (b) The name of the State agency to which the visit was made;
- (c) The dates on which the visit occurred;
- (d) An explanation of the purpose of the visit;
- (e) Copies of any reports, memoranda, notes, or other documents that were prepared by OMB personnel in connection with the visit.

3.) Have you or any other OMB officials ever had any conversations with any State officials regarding the 2176 waiver applications filed by their State? If so, please provide, for each such conversation:

- (a) The name and position of the OMB employees involved; and
- (b) The State represented by the official in question.

4.) Please provide the names and positions of each individual employed by OMB who has ever been involved, directly or indirectly, in the analysis, critique, discussion, development, implementation, or oversight of any policies or procedures relating in any way to the Medicaid home and community-based services waivers.

5.) Please provide an estimate of the number of hours of professional staff time expended by the individuals identified in the previous question in the analysis, critique, discussion, development, implementation, or oversight of any policies or procedures relating in any way to the 2176 waivers.

6.) Please provide the date and nature of each communication, verbal or written, between yourself and any HCFA official relating to the 2176 waiver statute or any individual State waiver application. Please submit copies of each of the written communications to the Subcommittee.

7.) Please describe fully the role of OMB in each of the following activities in connection with the administration of the 2176 waiver:

- (a) reviewing applications for new waivers;
 - (b) reviewing applications for renewals of expiring waivers;
 - (c) approving or disapproving applications for new waivers;
 - (d) approving or disapproving applications for expiring waivers;
 - (e) monitoring the operation of approved waivers by the States;
 - (f) providing technical assistance to the States in connection with the waiver applications;
 - (g) evaluating the operation of approved waivers by the States;
 - (h) developing policies or procedures relating to the waivers;
- and
- (i) responding to inquiries from Congress to the Health Care Financing Administration regarding the administration of the 2176 waiver authority.

In each instance, please provide a full justification for the OMB role.

8.) Please submit to the Subcommittee copies of all documents which describe, discuss, or otherwise relate to the role of OMB with respect to the administration of the 2176 waiver.

9.) At the hearing, Ms. Matula also testified that, this past February, HCFA officials told her that, as a condition of approval of her 2176 waiver application, the estimated costs for the waiver could not exceed 75 percent of the cost of nursing home care. As you know, this "75 percent" rule does not appear in either the text of, or preamble to, the March 13 waiver regulations.

(a) Did you or any other official at OMB ever suggest or require HCFA staff to apply this unwritten "75 percent" guideline, or any similar guideline, to State 2176 waiver applications?

(b) If so, state the statutory basis and policy rationale for such a guideline.

10.) At the hearing, Ms. Carol Kurland, who heads New Jersey's Office of Home Care Programs, testified that HCFA had told her State that, in the case of the 50-person "model" waivers, the "slot" of an individual who either returns to a nursing home or dies cannot be filled by an otherwise qualified individual until the following contract year. As you know, this "nonreplacement" rule does not appear in either the text of, or preamble to, the March 13 waiver regulations.

(a) Did you or any other official at OMB ever suggest or require HCFA staff to apply this unwritten "nonreplacement" rule, or any similar rule, to State "model" or other 2176 waivers?

(b) If so, state the statutory basis and policy rationale for such a guideline.

11.) By route slip dated June 15, 1984, David K. Kleinberg sent to two officials in the Department of Health and Human Services a memorandum captioned "1915(c) waiver policy: home and community-based services." In the covering note, the contents of the memorandum are identified as "suggestions" for a 2176 waiver policy. A copy of this document is attached for your convenience.

(a) Please submit to the Subcommittee any other documents prepared by OMB personnel, whether or not forwarded to HHS staff, which contain "suggestions" for a 2176 waiver policy.

(b) The first "principle" in Mr. Kleinberg's memorandum is that "1915(c) home and community-based waivers must result in aggregate Federal savings." Please explain the statutory basis for this "principle," citing the specific statutory language on which you are relying.

(c) The third "principle" in Mr. Kleinberg's memorandum is that "renewable 1915(c) waivers are appropriate only when, absent the waiver, state financing of the home and community services would not be cost effective." Please explain the statutory basis for this "principle," citing the specific statutory language on which you are relying.

(d) The final "principle" in Mr. Kleinberg's memorandum is that "one-time transition 1915(c) waivers may be appropriate when States would save money absent the waiver. The waiver could be encouraged through transition funding." Please explain the statutory basis for

this statement, citing the specific statutory language on which you are relying.

12.) As you are well aware, the Paperwork Reduction Act of 1980 has as one of its purposes "to minimize the Federal paperwork burden for... State and local governments...." At the hearing, State officials directly involved in administering the waivers characterized the reporting requirements in the March 13, 1985, waiver regulations as "excessive" and "a nightmare." According to the preamble to the regulations, OMB had at that point approved some but not all of the reporting and record-keeping requirements contained in the regulations, and by now, presumably, all of these requirements have received OMB approval, since they are being imposed on the States.

For each individual reporting or recordkeeping requirement imposed on the States by the March 13 regulations, please explain:

- (a) the purpose of the requirement;
- (b) the statutory basis for the requirement; and
- (c) the reason that the requirement is not burdensome.

13.) In his State of the Union message to the Congress last February, President Reagan stressed the values of "opportunity," "freedom," "family," and "neighborhood."

(a) What is the appropriate role of the Federal government in assuring that low income elderly, disabled, mentally retarded, developmentally disabled, and medically fragile children have access to high quality home and community-based services that will allow them the opportunity to enjoy freedom from institutional confinement and remain with their families and in their neighborhoods?

(b) How do the March 13 Medicaid community care waiver regulations, which, according to one expert State witness before the Subcommittee, "has the effect of stopping waivers in their tracks," promote the values of "opportunity," "freedom," "family," and "neighborhood" for these extremely vulnerable populations?

In closing, let me share with you a point I stressed at the hearing. The Subcommittee will not tolerate any retaliatory action against any of the witnesses, or the agencies or States they represent. In this regard, I invite your attention to section 1505 of Title 18 of the U.S. Code, which prohibits the obstruction of investigatory proceedings before Committees of Congress.

I look forward to receiving your timely and complete responses to these questions.

With all best wishes, I am

Sincerely,



Henry A. Waxman, Chairman,
Subcommittee on Health and
the Environment

cc: The Honorable Edward R. Madigan

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET

ROUTE SLIP

TO <u>Tony Itteilag</u>	Take necessary action	<input type="checkbox"/>
<u>Jim Scott (2 coys)</u>	Approval or signature	<input type="checkbox"/>
	Comment	<input type="checkbox"/>
	Prepare reply	<input type="checkbox"/>
	Discuss with me	<input type="checkbox"/>
	For your information	<input type="checkbox"/>
	See remarks below	<input type="checkbox"/>
FROM <u>David K. Kleinberg DKK</u>		DATE <u>6/15/84</u>

REMARKS

Attached are some suggestions for a 2176 Home and Community Based Services Waiver Policy as we discussed.

cc:

Alissa Fox

Debbie Brandel

OMB FORM 4

Rev. Aug 70

1915(c) Waiver Policy

DRAFT

Home and Community Based Services

I. Principles

- A. 1915(c) home and community-based waivers must result in aggregate Federal savings.
- B. 1915(c) waivers do not expand overall Medicaid capacity: 1915(c) waiver care substitutes for funded Medicaid certified ICF/SNF capacity.
- C. Renewable 1915(c) waivers are appropriate only when, absent the waiver, state financing of the home and community services would not be cost effective.
- D. One-time transition 1915(c) waivers may be appropriate when States would save money absent the waiver. The waiver could be encouraged through transition funding.

II. Implementation

- A. For a fixed, identified waiver population, total (all program) Federal costs under the waiver must not exceed costs for this population had the waiver not been granted.
- B. The 1915(c) waiver program must expand neither funded, Medicaid certified ICF/SNF capacity nor its Medicaid utilization.
- C. For 1915(c) waivers the Federal Government will match (at existing FFP rates) the costs of services beyond those in the State plan as permitted by sec. 1915(c).
- D. For transition waivers, the Federal Government will pay 75% of the added services costs in the first year of the waiver program, 50% in the second year, and 25% in the third year.

III. Conditions

- A. Separate proposals must be submitted for each target group (aged, MR, etc.) and each strategy (deinstitutionalization, diversion, etc).
- B. Maximum FFP limit for the institutionalized portion of the target group must be stated in the waiver request.
- C. State must fund and arrange an independent annual audit, which is eligible for normal (50%) administrative match.
- D. Renewable waivers must have completed evaluation data by



EXECUTIVE OFFICE OF THE PRESIDENT

OFFICE OF MANAGEMENT AND BUDGET

WASHINGTON, D.C. 20503

SEP 05 1985

Honorable Henry A. Waxman
 U.S. House of Representatives
 Committee on Energy and Commerce
 Washington, D.C. 20515

Dear Congressman Waxman:

Thank you for your July 3 letter concerning administration of the Medicaid home and community-based services waiver.

Your inquiry concerning implementation of the Medicaid home and community-based services program focuses on an excellent example of the broad range of ongoing intra-Executive Branch contacts between Cabinet Departments such as Health and Human Services (HHS) and the Office of Management and Budget (OMB). OMB's review of HHS's implementation of the Medicaid home and community-based services program, which constitutes 2% of the \$15.8 billion in Medicaid long-term care expenditures, illustrates the normal range of activities carried out by this agency.

As part of the Executive Office of the President, OMB is charged with performing a variety of government-wide functions on behalf of the President. Among these functions are:

- o clearing legislation, testimony and bill reports;
- o advising on regulations;
- o reducing the federal paperwork burden on the public;
- o improving management and productivity;
- o providing leadership to reduce and eliminate waste, fraud and abuse;
- o overseeing budget execution; and
- o setting Federal procurement policies and procedures.

OMB typically reviews and coordinates the testimony of Executive Branch officials presenting Administration positions and policies to the Congress. OMB also formulates the President's Budget for all Federal programs for submission to Congress. As concerns Medicaid, for example, OMB clears the HCFA Administrator's testimony on Medicaid or Supplementary Medical Insurance (SMI) issues before your Committee. Similarly, OMB is charged with approving Medicaid forms and other paperwork requests, with advising agencies on Medicaid regulations, and with recommending levels for the President's Medicaid appropriation request submitted to the Congress.

To achieve its mission, OMB is organized into four program divisions, relating to specific Cabinet departments, and divisions with cross-cutting roles. Human Resources, Veterans and Labor staff have budget-examining responsibility for a wide array of Federal programs, including Medicaid. On specific programmatic issues involving OMB's government-wide role, this staff works with the appropriate staff throughout OMB. Since a large, complex program like Medicaid touches upon many of OMB's government-wide concerns, it is handled by many different OMB components and staff throughout the course of a fiscal year:

- o The OMB Budget Review Division staff, has lead responsibility for preparing the President's Budget assuring that Medicaid financial documents and plans comport with proper budget concepts and rules, and for reviewing apportionments and HHS outlay plans. OMB Circulars A-11, A-34, and A-112, detail these activities and responsibilities, as well as their statutory bases.
- o OMB's Legislative Reference Division coordinates the legislative clearance process pursuant to OMB Circular A-19. This process affects all Executive Departments and their programs.
- o The Office of Information and Regulatory Affairs (OIRA) has lead responsibility in reviewing regulations such as the final regulation on Home and Community-Based Services published on March 13, 1985; similarly, OIRA approves paperwork reporting forms such as the HCFA-371 and 372, which States use to report data on their Home and Community-Based Services programs.
- o The OMB General Counsel's office reviews issues involving potential legal questions for Medicaid as well as other Federal programs.
- o The OMB Public Affairs office handles press and other public inquiries.
- o The OMB Legislative Affairs office deals with the Congress.
- o The OMB Planning and Communications Division provides a focal point for State, county, and local government officials and their concerns.
- o The OMB Management Improvement Division has lead responsibility for improving management efficiency and eliminating waste, fraud, and abuse.

- o The OMB Financial Management Division oversees a broad array of financial management, administrative control of funds, and cash-management issues, and
- o The OMB Office of Federal Procurement Policy establishes government-wide procurement policy.

As this summary suggests, the staff of the Associate Director for Human Resources, Veterans and Labor, which numbers fewer than 60 professionals and support personnel, and whose areas of programmatic responsibility include approximately \$450 billion in domestic programs in four Cabinet Departments and several independent agencies, work continuously with virtually all elements of OMB on literally thousands of issues and decisions. OMB staff maintain a broad range of contacts with staff in other Federal agencies as well as in State and local governments, typically gathering information and exploring ideas and policy alternatives on an informal basis. Because OMB staff are simultaneously involved with multiple, overlapping issues and because we do not record "billable hours" the way a lawyer in private practice might, it is impossible to specify how many hours of OMB staff time were devoted to any single area such as the home and community-based services portion of Medicaid.

Hopefully, the foregoing discussion of the role and operation of OMB will help place in context the answers to your specific questions, which are addressed in the remainder of this letter.

* * *

In response to your first question, the person to whom Ms. Matula referred is Gabriella Lupo, an economist in OMB's Special Studies Division for Human Resources, Veterans, and Labor (HRVL). Mrs. Lupo's trip, arranged by the HCFA regional office, was in the nature of a general orientation, designed to gain insight into how the waivers are working at the local level.

In her dealings with State officials, Mrs. Lupo made it clear that she was not involved in the waiver review process. Indeed, most of her time was spent in the field talking with project managers and waiver clients about client selection, intake procedures, and services provided.

No documents were prepared as a result of the trip because it was made to gather background information useful to HRVL efforts. Since the mid-1970's, the Division intermittently has worked on projects designed to better define and understand long-term care and to improve the data bases available for analysis on the subject. In 1980, for example, the division issued a report entitled "Data Sources on the Functionally Limited Elderly," prepared by the Interagency Statistical Committee on Long-Term Care established by the division. While both time and budget

constraints limit OMB staff's ability to visit the field, we believe it is important for them to have an understanding of how actions taken at the Federal level affect subject areas in which they perform analyses. Insights gained during the trip have been and will continue to be useful in structuring and interpreting research and data collection in the long-term care area.

As described above, the visits and conversations with State officials you inquire about in questions 2 and 3 are not uncommon, since OMB officials frequently talk or meet with State officials. Contact is probably most common between staff in the Planning and Communications division and such officials. Because the Medicaid home and community-based services waivers involve many staff throughout OMB, it is impossible to give you either an accurate accounting of the "names and positions of each individual", or an "estimate of the number of hours" that each has spent on their program, as requested in questions 4 and 5. In the course of carrying out our responsibility to review a Federal program such as Medicaid, there are almost certainly daily communications between the various staff elements of HCFA and OMB. Since these communications are part of our routine work, we do not keep the records necessary to answer question 6, regarding the date and nature of each communication, verbal or written.

As you know, HCFA administers, on behalf of the Secretary of HHS, the Medicaid program, including the home and community-based services program. I have described earlier in this letter OMB's role, responsibility, and internal organization, which responds to question 7. We have no unique arrangement or "documents which describe, discuss, or otherwise relate to the role of OMB with respect to the administration of the 2176 waivers", which responds to question 8.

In questions 9 and 10, you inquire about a so-called "75 percent" and "nonreplacement" rules. Neither the staff nor I are familiar with them.

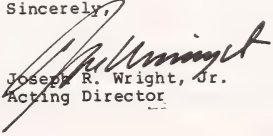
As I have explained above, various ideas and suggestions are frequently - indeed, constantly - considered between OMB and agency staff, especially in the development of policy. On occasion the ideas are discussed; sometimes they are written down. The note to which you refer in question 11 is part of this normal ongoing policy development process between OMB and agencies. As you know, the final home and community-based services regulation evolved over time and is substantially different from this early attempt to focus a discussion.

In question 12 you inquire about reporting burdens associated with Medicaid waivers. Under Sections 1915(c) (and (e)) of the Social Security Act, Congress has required States to provide information on their waivers programs and the Secretary to report on the waiver program to the Congress. As the administering agency, HCFA is better positioned to answer questions on the specific details and rationales relating to Medicaid administration.

As you note in question 13, this Administration is committed to basic values as "opportunity", "freedom", and "family" and "neighborhood". The Administration is committed to more cost-effective alternatives to long-term care. President Reagan first brought to light the red tape nightmare that Katie Beckett faced in seeking home care instead of institutional care. Since then, HHS has approved home care programs in nearly all States, helping thousands of "Katie Becketts" to come home.

I appreciate your concern and thank you for inquiry. Please let me know if I can be of further assistance to you.

Sincerely,


Joseph R. Wright, Jr.
Acting Director

Mr. WAXMAN. Dr. Davis, I want to welcome you. Without objection, your prepared statement will be made part of the record in full. We would like to ask you to summarize that statement in 5 minutes so we can have an opportunity for questions.

STATEMENT OF CAROLYNE DAVIS, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY ROBERT WREN, DIRECTOR, OFFICE OF COVERAGE POLICY

Ms. DAVIS. I would like to introduce Mr. Robert Wren, Director of the Health Care Financing Administration's Office of Coverage Policy, who is on my left.

As all of you know, the payments for institutional long-term care services have certainly been increasing and are a larger and larger part of the Medicaid budget. Indeed, if we look ahead to the 1990's, we will find we are going to estimate a doubling of these payments if current utilization trends continue.

It has been estimated also that a quarter of the nursing home population might be better served in the community, but for lack of the health and special services that are available in the home and community. As a result of those two factors, Congress did authorize the home and community-home-based waiver program which can be used to expand the range of services available and provide flexibility regarding who can receive those services. In some cases the waivers can be used to extend Medicaid coverage to persons who wouldn't be eligible outside of an institution.

Mr. WAXMAN. I am having trouble hearing you.

Ms. DAVIS. I think it is important to recognize, in expanding the range of services available and in providing flexibility regarding who can and can't receive the services, that we need to look also at the requirement that the services must be furnished under an individual plan of care to persons who would otherwise require the level of care provided in a skilled nursing facility or intermediate care facility.

Second, the services must be necessary to avoid institutionalization and not increase the program costs in general; and, third, recreational activities and vocational training can't be covered under the waiver because they are not covered under general Medicaid services.

The law also authorizes a category of eligibility for individuals at home who would otherwise be eligible only when they are in an institution. And we are familiar, of course, with Katie Beckett, who now lives at home and is covered under this provision and was the model for many others.

I think it is important as you look at program operations to recognize that we have expended a great deal of time and energy in the agency toward assisting in the development of filing applications for these particular program waivers. Waiver requests can be deemed approved unless the Department, through HCFA, disapproves or requests additional information within a 90-day timeframe.

There has been mention here about the 90-day timeframe, and, frankly speaking, we resort to telephone calls in order to expedite

the information that we need during that time period because it is a very, very tight timeframe for us. If we resorted to letters back and forth in the mail, I think we would be extending the timeframes even longer. And, of course, we frankly have tried very hard to never have a situation in which the 90 days appeared and we took no action whatsoever.

We have expended a considerable amount of time and resources in providing States with technical assistance. For example, we have used the central office and the Philadelphia Regional Office, who both worked extensively with the State of Maryland, to develop for its full-scale waiver for the mentally retarded. We have about 10 full-time equivalent individuals who work on the evaluation and assessment and providing of technical assistance, in the central office, as well as some individuals in the regional office.

We have twice now sent out material that relates to information that we need for approval of a model waiver. Also, we sent out a very definitive model so that the States could follow it for the use of Katie Beckett or other models which cover up to under 50 individuals.

We try at each one of our Medicaid conferences to schedule a discussion on community-based home services. We work very intensively to avoid a nonrenewal or termination. In the case of the renewal requests in which the major problems are identified, such as in Oregon, we exercised our authority to grant an extension in order to give the State time to resolve some of the problems we identified in their original program, and we have worked closely with the State staffs to secure what modifications we need to the waiver or to the renewals.

The opportunity offered by these waivers is enormous, and we have heard the personal experiences of persons sitting at this very table today whose lives have been heavily enriched by the program. Personally, I have taken the time and opportunity to visit homes of individuals who had been deinstitutionalized and provided with community home-based services. I can tell you indeed it is a satisfaction to know that those services are able to bring about such an important contribution.

But it is important to remember that there is a possibility that the program can be poorly managed or can lead to excessive costs. We have known for some time now, from a number of demonstrations, that it is hard to cover home and community-based services in a cost effective manner unless one targets to provide those services only to individuals who would otherwise be institutionalized.

We also are mindful of the fact that indeed, individuals can be covered within an overall program framework who are not suitable for institutionalization, and we do need to assess that and make certain that is not happening. In several cases we have found where States have covered populations that would not have been in need of institutionalization and, therefore, would not have been covered under the Medicaid waiver.

It was an outgrowth of some of those assessments that led us to structure the regulations in the manner in which they were finalized. But let me assure you that the requirements we have aren't meant to harm the program or impede its operation. I think, without the oversight, we believe that the waiver program could fail to

meet its expectations. The regulations and requirements are designed in such a fashion as to avoid the significant, unexpected increases in the program dollars and to avoid potential problems that could be related to the quality of care. There are instances, we have discovered, where unqualified providers of care were giving services, and I don't believe any of us want that to happen. So the requirements help to assure the aggregate costs won't be increasing, while we are enabling those in need of the services to remain at home and to receive those services.

The program is clearly still in its early stages for most of the States, and evaluation material is really very sketchy at this point in time, because although nearly every State has one waiver, many of those are only 1 or 2 years old. And data from costs as well as the evaluation component are slow in coming in as a result of that.

However, we have approved 104 waiver requests that are both regular and model waivers from some 46 States. Two-thirds of them are from the elderly and disabled. The mentally retarded we believe represent a particularly significant target group in the waiver program also. Most of the waivers are for a range of services, but it is very clear that case management seems to be the most frequently requested service, with respite care and personal care services and habilitation for the mentally retarded also important activities.

We are conducting an independent evaluation on the impact of the program, studying the effects of the waiver program on reducing institutionalization and on maintaining the current costs, preventing cost shifting from other funded assistance programs, and looking at the quality of care. The evaluation study, which was initiated in late 1983, will be completed in 1986.

Our observations, however, are in terms of first impressions, that there is going to be more and more high-level intra agency communication within the States, and I think in the initial year's formulation of the program that was somewhat difficult to come by. Evidence too from some of the few State cost reports we have reviewed is that the original waiver formula caseloads and projections of costs weren't particularly accurate.

In conclusion, I think it is fair to say the flexibility afforded the States by the availability of the waiver has been taken advantage of. Clearly we have 46 States who feel it is an important program. We believe we are gaining needed experience on how to target the home and community-based services more effectively and to develop a more coordinated network to deliver the services and to maintain an appropriate information system to allow us to monitor the systems programs.

I would like to conclude by saying we are not out to destroy the program, but rather to protect the quality of the program, the quality of care, the safety of beneficiaries and to provide some fiscal accountability.

I would be happy to answer your questions.

[Testimony resumes on p. 282.]

[The prepared statement of Ms. Davis follows:]

STATEMENT OF

CAROLYNE K. DAVIS, PH.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

MR. CHAIRMAN, I AM PLEASED TO BE HERE TODAY TO DISCUSS OUR EXPERIENCE WITH THE MEDICAID HOME AND COMMUNITY-BASED WAIVER PROGRAM. I AM ACCOMPANIED BY ROBERT WREN, DIRECTOR OF THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) OFFICE OF COVERAGE POLICY IN THE BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE.

BACKGROUND

AS YOU KNOW, PAYMENTS FOR INSTITUTIONAL LONG-TERM CARE SERVICES UNDER MEDICAID ACCOUNT FOR AN INCREASINGLY LARGER SHARE OF THE MEDICAID BUDGET. IN 1983, PAYMENTS OF ALMOST \$14 BILLION IN FEDERAL AND STATE FUNDS REPRESENTED 43 PERCENT OF ALL PROGRAM COSTS. BY 1990, THESE PAYMENTS CAN BE EXPECTED TO DOUBLE, IF CURRENT UTILIZATION TRENDS CONTINUE.

IT HAS BEEN ESTIMATED BY SOME THAT A QUARTER OF THE CURRENT NURSING HOME POPULATION MIGHT BE BETTER SERVED IN THE COMMUNITY. MANY ELDERLY, DISABLED AND CHRONICALLY ILL PERSONS LIVE IN INSTITUTIONS NOT SOLELY FOR MEDICAL REASONS, BUT BECAUSE OF LACK OF AFFORDABLE HEALTH AND SOCIAL SERVICES AVAILABLE TO THEM IN THEIR HOMES OR COMMUNITIES, DUE TO INDIVIDUAL'S INABILITY TO PAY FOR THOSE SERVICES OR THE FAILURE OF THE STATE PLAN TO COVER THEM WHEN THEY DO EXIST.

FURTHER, ASSESSMENT PROCEDURES REQUIRED UNDER MEDICAID TO DETERMINE THE NEED FOR INSTITUTIONAL CARE FOR THE ELDERLY AND DISABLED MAY NOT BE ADEQUATE IN PREVENTING AVOIDABLE ADMISSIONS WHERE APPROPRIATE HOME AND COMMUNITY SERVICES ARE NOT AVAILABLE AND THEREFORE MAY NOT BE FACTORED IN. MOST OF THE REVIEWS OCCUR AFTER ADMISSION TO THE LONG-TERM CARE FACILITY, WHEN IT IS MOST

DIFFICULT TO DISCHARGE THE RESIDENT BACK TO THE COMMUNITY. IN ADDITION, THE REVIEWS FOCUS PRIMARILY ON MEDICAL CONDITIONS, AND NOT ON SOCIAL AND OTHER FACTORS THAT ARE OFTEN MORE CRITICAL IN DETERMINING THE MOST SUITABLE PLACEMENT.

IN AN EFFORT TO ADDRESS THESE CONCERNS, SECTION 2176 OF P. L. 97-35 (OBRA) WAS ENACTED, ADDING A NEW SECTION 1915(c) TO THE SOCIAL SECURITY ACT. THIS SUBSECTION AUTHORIZES THE SECRETARY OF HHS TO WAIVE CERTAIN MEDICAID STATUTORY LIMITATIONS IN ORDER TO ENABLE A STATE TO COVER A BROAD ARRAY OF HOME AND COMMUNITY-BASED SERVICES. ALL SUCH SERVICES MUST BE FURNISHED UNDER AN INDIVIDUAL WRITTEN PLAN OF CARE, AND MAY ONLY BE FURNISHED TO PERSONS WHO WOULD OTHERWISE REQUIRE THE LEVEL OF CARE PROVIDED IN A SKILLED NURSING FACILITY (SNF) OR INTERMEDIATE CARE FACILITY (ICF) FOR WHICH THE COST COULD BE REIMBURSED UNDER THE STATE PLAN.

MANY OF THE SERVICES AUTHORIZED BY SECTION 2176 WOULD BE AUTOMATICALLY ELIGIBLE FOR FEDERAL REIMBURSEMENT IF A STATE CHOSE TO OFFER THEM BY AMENDING ITS STATE PLAN. GENERALLY IT IS WHERE A STATE WISHES TO RESTRICT THE AVAILABILITY OF SERVICES TO SPECIAL GROUPS, AND FREQUENTLY TO SELECTED GEOGRAPHIC AREAS, THAT IT MUST APPLY FOR A WAIVER UNDER SECTION 2176.

UNDER A HOME AND COMMUNITY-BASED SERVICES WAIVER, A STATE MAY PROVIDE SERVICES ON A MORE RESTRICTIVE BASIS THAN THOSE SERVICES OFFERED UNDER THEIR STATE PLAN. THESE SERVICES, HOWEVER, MUST

BE CONSISTENT WITH PLANS OF CARE WHICH ARE SUBJECT TO THE STATE'S APPROVAL, AND MUST BE NECESSARY TO AVOID INSTITUTIONALIZATION AS WELL AS COST-EFFECTIVE. PURELY DIVERSIONAL OR RECREATIONAL ACTIVITIES AND VOCATIONAL TRAINING MAY NOT BE COVERED AS MEDICAL ASSISTANCE UNDER A HOME AND COMMUNITY-BASED WAIVER.

ADDITIONALLY, THE LAW SPECIFICALLY PROVIDES THAT A HOME AND COMMUNITY-BASED SERVICES WAIVER MAY INCLUDE A WAIVER OF "STATEWIDENESS" AND "COMPARABILITY" REQUIREMENTS. THIS MEANS THAT HOME AND COMMUNITY-BASED SERVICES DO NOT HAVE TO BE PROVIDED THROUGHOUT THE STATE, AND A STATE CAN TARGET HOME AND COMMUNITY-BASED SERVICES TO A SPECIFIC GROUP OF ELIGIBLES, SUCH AS THE DEVELOPMENTALLY DISABLED. THE STATE IS NOT REQUIRED TO PROVIDE THE SERVICES TO ALL ELIGIBLE INDIVIDUALS WHO REQUIRE A SNF OR ICF (INCLUDING AN INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED) LEVEL OF CARE. UNDER THE WAIVER, THE STATE MAY ALSO EXCLUDE THOSE INDIVIDUALS FOR WHOM THERE IS A REASONABLE EXPECTATION THAT HOME AND COMMUNITY-BASED SERVICES WOULD BE MORE EXPENSIVE THAN MEDICAID SERVICES THE INDIVIDUAL WOULD OTHERWISE RECEIVE IN AN INSTITUTION.

LASTLY, THE LAW ALSO AUTHORIZES OPTIONAL CATEGORICAL ELIGIBILITY TO INDIVIDUALS AT HOME WHO WOULD BE ELIGIBLE UNDER THE STATE PLAN IF THEY WERE IN A MEDICAL INSTITUTION WHERE THE FAMILY'S INCOME AND RESOURCES WOULD NO LONGER APPLY TOWARD DETERMINING THEIR MEDICAID ELIGIBILITY. THIS MEANS THAT CHILDREN SUCH AS KATIE

BECKETT, WHO ARE READY TO GO HOME, WHOSE PARENTS OBVIOUSLY WANT THEM AT HOME, AND WHO CAN BE TREATED AT LESS COST AT HOME, CAN NOW LIVE AT HOME AND STILL BE COVERED BY MEDICAID.

IN SUMMARY, HOME AND COMMUNITY-BASED WAIVERS CAN BE USED TO EXPAND THE RANGE OF SERVICES AVAILABLE; PROVIDE FLEXIBILITY REGARDING WHO CAN RECEIVE WHICH SERVICES; AND, IN SOME LIMITED CASES, EXTEND MEDICAID COVERAGE TO PERSONS WHO OTHERWISE WOULD NOT BE ELIGIBLE OUTSIDE AN INSTITUTION.

WAIVER REQUIREMENTS

THE OPPORTUNITIES THAT THESE WAIVERS AFFORD ARE ENORMOUS. WE HAVE HEARD TODAY THE PERSONAL EXPERIENCES OF FRAIL OR DISABLED PERSONS WHOSE LIVES HAVE BEEN ENRICHED BY THIS PROGRAM. I HAVE PERSONALLY VISITED THE HOMES OF PERSONS WHO, BUT FOR HOME AND COMMUNITY-BASED SERVICES, WOULD BE IN AN INSTITUTION. I KNOW THE SATISFACTION THESE SERVICES CAN BRING. I ALSO KNOW, HOWEVER, THAT IT IS POSSIBLE THAT THE PROGRAM CAN BE ABUSED, POORLY MANAGED, OR BE EXCESSIVELY COSTLY.

THE SECTION 2176 LEGISLATION INCLUDED THE REQUIREMENT THAT THE WAIVERS BE COST-EFFECTIVE. EXPERIENCE FROM A DECADE OF

DEMONSTRATIONS SHOWS HOW HARD IT IS TO COVER HOME AND COMMUNITY-BASED SERVICES IN A COST-EFFECTIVE MANNER. SOME OF THE BIGGEST PROBLEMS ARE:

- O TARGETING THE PROGRAM TO THE APPROPRIATE POPULATION, THAT IS, THOSE MOST AT RISK OF NEEDING INSTITUTIONAL CARE -- WE MUST FOCUS ON THIS GROUP TO MAKE THE WAIVER PROGRAM MAKE SENSE FOR MEDICAID, AND TO COMPLY WITH THE LEGISLATION.
- O COST SHIFTING IS ALWAYS A POSSIBILITY -- OTHER STATE-FINANCED OR FEDERAL PROGRAMS WHICH CAN PROVIDE SIMILAR CARE ARE USUALLY TIGHTLY CAPPED.
- O INCREASED USE OF ACUTE CARE BY THE WAIVER POPULATION IS POSSIBLE -- THE WAIVER POPULATION MAY INCUR INCREASED COSTS FOR PHYSICIAN AND HOSPITAL CARE, RESULTING IN GREATER TOTAL COSTS TO MEDICAID THAN WITHOUT THE WAIVER.

TO ASSURE COST-EFFECTIVENESS AND TO ASSURE THE HEALTH AND WELFARE OF THE SELECTED GROUP OR INDIVIDUAL BENEFICIARIES, THE STATES MUST MEET CERTAIN REQUIREMENTS TO BE GRANTED A WAIVER. AMONG THESE ARE THE FOLLOWING:

- O ASSURANCES MUST BE PROVIDED THAT THE NECESSARY SAFEGUARDS HAVE BEEN TAKEN TO ASSURE THE HEALTH AND WELFARE OF BENEFICIARIES.

- O BOARD AND CARE FACILITIES IN WHICH WAIVER SERVICES ARE FURNISHED MUST MEET LOCAL HEALTH AND SAFETY REQUIREMENTS.
- O TOTAL MEDICAID COSTS -- ACUTE AND LONG-TERM CARE --WILL NOT BE ANY GREATER THAN WITHOUT THE WAIVER.
- O THE NUMBER OF PERSONS SERVED OUTSIDE INSTITUTIONS CANNOT BE GREATER THAN THE NUMBER OF LONG-TERM CARE BEDS THAT WOULD HAVE BEEN AVAILABLE FOR THOSE INDIVIDUALS.
- O FINANCIAL ACCOUNTABILITY MUST BE PROVIDED INCLUDING AN INDEPENDENT AUDIT OF STATE WAIVER EXPENDITURES IN MOST CASES AS WELL AS AN INDEPENDENT ASSESSMENT OF EACH WAIVER PROGRAM THAT EVALUATE THE QUALITY OF CARE PROVIDED, ACCESS TO CARE, AND COST EFFECTIVENESS.
- O AN EVALUATION (AND PERIODIC REEVALUATIONS) MUST BE PERFORMED OF AN INDIVIDUAL'S NEED FOR THE LEVEL OF CARE PROVIDED IN A SNF AND ICF.

FAILURE TO MEET THESE REQUIREMENTS COULD RESULT IN FINANCIAL PENALTIES OR WAIVER TERMINATION.

LET ME ASSURE YOU THAT THESE REQUIREMENTS ARE NOT MEANT TO HARM THE PROGRAM OR IMPEDE ITS OPERATIONS. WITHOUT OUR OVERSIGHT AND THESE REQUIREMENTS, I BELIEVE THAT THE WAIVER PROGRAM COULD FAIL TO MEET OUR MUTUAL EXPECTATIONS. THESE REQUIREMENTS ARE NEEDED TO AVOID SIGNIFICANT UNEXPECTED INCREASES IN PROGRAM DOLLARS AND POTENTIAL PROBLEMS RELATED TO THE QUALITY OF CARE. THESE REQUIREMENTS HELP ASSURE THAT THE PROGRAM REMAINS COST-EFFECTIVE WHILE ENABLING CERTAIN FRAIL AND DISABLED CITIZENS TO REMAIN AT HOME AND RECEIVE NEEDED SERVICES.

PROGRAM OPERATION

WAIVER REQUESTS ARE DEEMED APPROVED UNLESS THE DEPARTMENT, THROUGH HCFA, DISAPPROVES OR REQUESTS ADDITIONAL INFORMATION WITHIN 90 DAYS OF RECEIPT.

SINCE THE PROGRAM'S INCEPTION, HCFA HAS EXPENDED CONSIDERABLE TIME AND RESOURCES IN FACE-TO-FACE AND INFORMAL TELEPHONE CONTACT WITH STATES TO PROVIDE THEM WITH TECHNICAL ASSISTANCE IN DEVELOPING APPROVABLE WAIVER PROPOSALS AND RENEWAL REQUESTS THAT FULLY CONFORM TO STATUTORY AND REGULATORY REQUIREMENTS. MOST WAIVER REQUESTS HAVE REQUIRED FORMAL HHS REQUESTS FOR ADDITIONAL INFORMATION, PARTICULARLY RELATING TO STATES' COST AND UTILIZATION ESTIMATES BECAUSE THE INITIAL DOCUMENTATION WAS INSUFFICIENT.

AS A SPECIFIC EXAMPLE OF OUR WORK WITH THE STATES, MY STAFF MET ON SEVERAL OCCASIONS WITH STAFF FROM THE STATE OF MARYLAND WHILE MARYLAND WAS DEVELOPING ITS MODEL WAIVER TO SERVE VENTILATOR-DEPENDENT CHILDREN AND ITS FULL-SCALE WAIVER TO SERVE THE MENTALLY RETARDED/DEVELOPMENTALLY DISABLED. STAFF FROM BOTH OUR PHILADELPHIA REGIONAL OFFICE AND OUR CENTRAL OFFICE WORKED INTENSIVELY WITH THE STATE TO DEVELOP DATA NEEDED FOR APPROVAL OF THESE PROGRAMS. I WAS PLEASED TO APPROVE BOTH OF THESE WAIVERS WHICH ARE NOW OPERATIONAL.

HCFA HAS ALSO WORKED VERY INTENSELY WITH STATES TO AVOID NON-RENEWAL OR TERMINATION OF THEIR WAIVER PROGRAMS. IN THE CASE OF RENEWAL REQUESTS IN WHICH MAJOR PROBLEMS WERE IDENTIFIED -- AS IN OREGON, FOR EXAMPLE -- WE HAVE EXERCISED OUR AUTHORITY TO GRANT EXTENSIONS IN ORDER TO GIVE THE STATE TIME TO RESOLVE THE PROBLEMS FOUND IN THE ORIGINAL PROGRAM. WE ALSO WORK VERY CLOSELY WITH STATE STAFF TO SECURE WHATEVER MODIFICATIONS TO WAIVER PROPOSALS OR RENEWALS ARE NEEDED TO APPROVE THE WAIVER.

WE ESTIMATE THAT 200 HCFA STAFF HOURS ARE SPENT IN REVIEWING INITIAL WAIVERS AND ABOUT 300 ON RENEWALS. IN FACT, WE BELIEVE THAT IF WE DID NOT DEVOTE THESE SUBSTANTIAL STAFF RESOURCES TO THIS TECHNICAL ASSISTANCE EFFORT, VERY FEW WAIVER APPLICATIONS COULD HAVE BEEN APPROVED.

EXPERIENCE OF WAIVER PROGRAMS

BECAUSE THE PROGRAM IS STILL IN ITS EARLY STAGES IN MOST STATES, ONLY PRELIMINARY INFORMATION ON THE EXPERIENCE UNDER THE SECTION 2176 WAIVER PROGRAM IS AVAILABLE AT THIS TIME. I WOULD LIKE TO HIGHLIGHT SOME OF THIS INFORMATION.

- O STATE RESPONSE TO THE SECTION 2176 WAIVER PROGRAM OPTION HAS BEEN REMARKABLY ENTHUSIASTIC. AS OF MAY 31, 1985, THE DEPARTMENT HAD RECEIVED 169 REQUESTS FOR WAIVERS (REGULAR AND MODEL) FROM 47 STATES. THE DEPARTMENT HAD APPROVED 104 OF THESE REQUESTS FROM 46 STATES. THUS, NEARLY EVERY STATE HAS AT LEAST ONE WAIVER.
- O AS OF JUNE 1984, BASED ON STATE PROJECTIONS, APPROXIMATELY 53,300 PERSONS HAD BEEN PROVIDED HOME AND COMMUNITY-BASED SERVICES UNDER THE WAIVER AUTHORITY, A NUMBER EQUALING ABOUT 3.5 PERCENT OF THE TOTAL MEDICAID LONG-TERM CARE INSTITUTIONAL CASELOAD.
- O ABOUT TWO-THIRDS OF THE WAIVERED POPULATION ARE THE ELDERLY AND DISABLED. THESE 34,500 PERSONS REPRESENT ABOUT 2.5 PERCENT OF THE MEDICAID ICF AND SNF POPULATION.

- O THE MENTALLY RETARDED REPRESENTED A PARTICULARLY SIGNIFICANT TARGET GROUP IN WAIVER PROGRAMS EVALUATED AS OF JUNE 1984. AS ESTIMATED 17,000 ARE RECEIVING WAIVERED SERVICES WHICH REPRESENT 11.3 PERCENT OF THE TOTAL ICF/MR POPULATION.
- O PROGRAMS TARGETED TO THE CHRONIC MENTALLY ILL SERVE APPROXIMATELY 1,500 TOTAL RECIPIENTS.
- O MOST WAIVERS PROVIDE FOR A RANGE OF SERVICES. BY FAR, THE HOME AND COMMUNITY SERVICE MOST FREQUENTLY PROVIDED IS CASE MANAGEMENT. RESPITE CARE AND HOMEMAKER/HOME HEALTH AIDE SERVICES ARE FREQUENTLY PROVIDED FOLLOWED BY ADULT DAY HEALTH, PERSONAL CARE, TRANSPORTATION, AND HOME MODIFICATIONS. FOR WAIVERS TARGETED TO THE MENTALLY RETARDED/DEVELOPMENTALLY DISABLED POPULATION, HABILITATION SERVICES ARE MOST FREQUENTLY PROVIDED.

WAIVER PROGRAM EVALUATION

THE DEPARTMENT IS CONDUCTING A THOROUGH INDEPENDENT EVALUATION OF THE IMPACT OF THE SECTION 2176 WAIVER PROGRAM THROUGH HCFA'S OFFICE OF RESEARCH AND DEMONSTRATIONS. THE EVALUATION IS STUDYING THE EFFECT OF THE WAIVER PROGRAM ON REDUCING

INSTITUTIONALIZATION; REDUCING OR MAINTAINING CURRENT COSTS; COST SHIFTING FROM OTHER FEDERALLY FUNDED ASSISTANCE PROGRAMS; AND QUALITY OF CARE. THE EVALUATION STUDY, BEGUN IN LATE 1983 AND SCHEDULED TO RUN THROUGH SEPTEMBER 1986, WILL PRODUCE ANNUAL INTERIM REPORTS. THE FIRST OF THESE, WHICH IS PRIMARILY DESCRIPTIVE OF FEATURES OF THE EARLIEST OPERATIONAL WAIVER PROGRAMS, IS CURRENTLY BEING REVIEWED AND WILL BE MADE AVAILABLE TO THE CONGRESS AND THE STATES SHORTLY.

WHILE I AM HAPPY TO SHARE SOME OF ITS FINDINGS WITH YOU HERE TODAY, THE REPORT INDICATES CLEARLY THAT IT IS STILL TOO EARLY TO PERFORM ANY RIGOROUS ANALYSIS OF THE PROGRAM FROM THE LIMITED DATA AVAILABLE AT THE TIME THE STUDY WAS IN PROGRESS. THEREFORE, THE FOLLOWING OBSERVATIONS MUST BE REGARDED AS FIRST IMPRESSIONS:

- O SECTION 2176 WAIVER PROGRAMS ARE HIGHLY DIVERSE. TARGET POPULATIONS, SCREENING CRITERIA, CASE MANAGEMENT SYSTEMS, SERVICE DELIVERY NETWORKS, AND REIMBURSEMENT METHODS DIFFER WIDELY. SOME STATES IMPOSE RESTRICTIVE TARGETING CRITERIA TO INCREASE THE LIKELIHOOD THAT WAIVER RECIPIENTS WOULD HAVE BEEN INSTITUTIONALIZED BUT FOR THE PROGRAM. OTHER STATES REQUIRE ONLY THAT WAIVER RECIPIENTS WOULD OTHERWISE QUALIFY FOR NURSING HOME ADMISSION. WAIVER PROGRAMS ARE ALSO EVOLVING FAIRLY QUICKLY AS STATES GAIN EXPERIENCE WITH THE DELIVERY OF HOME AND COMMUNITY-BASED SERVICES THROUGH MEDICAID.

- O MANY STATES HAVE EXPERIENCED DELAYS IN IMPLEMENTING THEIR SECTION 2176 WAIVER PROGRAMS. ONE MAJOR REASON FOR THESE DELAYS IS THAT ADMINISTRATION OF STATE WAIVER PROGRAMS IS FREQUENTLY DIVIDED BETWEEN STATE MEDICAID AGENCIES AND OTHER STATE OR LOCAL AGENCIES WHICH HAVE PROGRAMMATIC EXPERTISE WITH THE TARGET POPULATION BUT LITTLE EXPERIENCE WITH MEDICAID REQUIREMENTS. INTERAGENCY COMMUNICATION AND COOPERATION IS OFTEN THE FIRST STEP IN THE IMPLEMENTATION PROCESS, AND THIS TAKES TIME TO DEVELOP.
- O DUE TO DELAYS IN PROGRAM IMPLEMENTATION AND LAGS BY THE STATES IN THE SUBMISSION OF ANNUAL REPORTS ON WAIVER PROGRAM EXPENDITURES, DATA ON THE ACTUAL COST IMPACTS OF THE PROGRAM ARE STILL EXTREMELY SKETCHY. THE MAJOR CONCLUSION FROM THE FEW STATE REPORTS AVAILABLE IS THAT ORIGINAL WAIVER FORMULA CASELOAD AND COST PROJECTIONS HAVE NOT BEEN PARTICULARLY ACCURATE.
- O HCFA MONITORING OF SECTION 2176 WAIVER PROGRAMS HAS FOUND THAT STATES ARE GENERALLY IMPLEMENTING THE PROGRAM IN CONFORMANCE WITH STATUTORY REQUIREMENTS. FINDINGS OF NON-ADHERENCE, WHILE NUMEROUS, HAVE TYPICALLY BEEN CORRECTABLE. MOST ARE RELATED TO THE MAINTENANCE OF ADEQUATE RECORDS AND INFORMATION TO SUPPORT FINANCIAL ACCOUNTABILITY.

CONCLUSION

IT IS CLEAR THAT THE FLEXIBILITY AFFORDED STATES BY THE AVAILABILITY OF WAIVERS HAS BEEN WELCOMED. PROGRAMS NOW IN OPERATION ARE GAINING NEEDED EXPERIENCE IN HOW TO TARGET HOME AND COMMUNITY-BASED SERVICES EFFECTIVELY, HOW TO DEVELOP COORDINATED PROVIDER NETWORKS TO DELIVER SERVICES EFFICIENTLY, AND HOW TO DEVELOP THE INFORMATION SYSTEMS WHICH ALLOW THEM TO MONITOR THEIR PROGRAMS AND MAKE IMPROVEMENTS. STATES ARE ALSO SHARING THEIR INDIVIDUAL EXPERIENCES WITH EACH OTHER ON A REGULAR BASIS. THIS IS AN ENCOURAGING DEVELOPMENT WHICH CAN RESULT IN REPLICATION OF THE BEST, MOST SUCCESSFUL PROGRAM PRACTICES.

WE ARE HOPEFUL THAT WE HAVE DESIGNED A PROGRAM WHICH CAN OFFER THE WELCOMED FLEXIBILITY TO PROVIDE HOME AND COMMUNITY-BASED SERVICES UNDER MEDICAID WITHIN STATUTORILY-IMPOSED COST CONSTRAINTS.

I WILL BE HAPPY TO RESPOND TO ANY QUESTIONS THE COMMITTEE MAY HAVE.

Mr. WAXMAN. Thank you very much, Dr. Davis. We are going to submit some questions to you in writing, but I would like to ask you a few questions now. [See p. 294.]

You conclude in your written statement with the hope that "we have designed a program which can offer the welcomed flexibility to provide home and community-based services under Medicaid within statutorily-imposed cost constraints." We just heard testimony from State officials that the March 13th regulations are inflexible. Perhaps you have heard from other States in addition to those who testified this morning.

Can you cite any State that has indicated unqualified support for the March 13th regulations? How do you explain the sharp difference of opinion between you and the States on the issue of flexibility?

Ms. DAVIS. I have not had the opportunity to read the material that has come in as a result of our final publication. As to whether or not there has been a State that has indicated total support for our system, I can't speak to that. I think, in general, many of the States are aware of the fact we are struggling to try to maintain the quality of the program, but yet we do have a fiscal responsibility for making certain that we are not spending more.

It is true that the statute calls for it to be budget neutral, but unless individual States are held accountable for not spending more than what they had initially determined they were going to spend, it is possible we would be spending more.

Mr. WAXMAN. We are hearing lots of complaints from States. They feel their hands are being tied. You stated in your prepared testimony to us it is still too early to perform any rigorous analysis of the program from the limited data available. If the data are unavailable and no analysis has been done, how can you justify issuing those March 13 regulations? Can you cite any state practices or abuses which might justify such stringent rules?

Ms. DAVIS. Yes, sir, I certainly can. There are several States that really exceeded the number of persons or costs which they had projected. Once we had approved a waiver for about 3,500 recipients and the State actually provided service for over 7,000, we looked at the number of individuals that were being provided service. We established some of those individuals would not have received services within an institution, and consequently that was an additional cost to the Medicaid Program.

Another State received a waiver to provide services for a number of individuals, and when we looked into it, we found some of them would have been satisfactorily treated in an outpatient clinic rather than in an inpatient setting. Therefore, they would never have been included under a Medicaid Program in general.

Another State converted a group that was wholly State funded in a sheltered workshop program—

Mr. WAXMAN. Which group would that be?

Ms. DAVIS. It was Louisiana.

Mr. WAXMAN. What group did they convert?

Ms. DAVIS. A State sheltered program into the waiver. The program would not normally be financed under the Medicaid. A majority of those clients would not have ended up in a Medicaid institution, and, therefore, that constituted an additional cost.

Mr. WAXMAN. Wouldn't they be mentally retarded?

Ms. DAVIS. It is quite possible.

Mr. WAXMAN. Wouldn't they be covered under Medicaid?

Ms. DAVIS. No, sir, not unless they were within the institution.

Mr. WAXMAN. But they weren't in an institution, they were in a workshop?

Ms. DAVIS. That is right.

Mr. WAXMAN. Wouldn't the result of your denying funds to those people in the workshop be to send them to the institution?

Ms. DAVIS. No. The point being made here is there are other programs that support those services and would have supported those programs.

Mr. WAXMAN. You cited some examples. I can't evaluate, but you can, how isolated those examples may be and whether in adopting these regulations as a result of a few instances of misapplication of the program by the States you are punishing all the States, with excessively stringent controls.

The 2176 statute gives the authority to grant these waivers to the Department of Health and Human Services, but we are hearing reports about the involvement of the Office of Management and Budget. The statute never talked about the Office of Management and Budget running the program, only the Department.

Why are they so active in reviewing these waiver applications? Would you describe for us the current role of OMB in the area of waiver applications?

Ms. DAVIS. The current role is simply that of the normal oversight that the President's budget would hold for any authority. We provide OMB with a monthly report of waivers we are granting, and they track that, just as they do track any other expenditures that an institution has.

Mr. WAXMAN. Did they have a role in preparing these March 13 regulations?

Ms. DAVIS. They, under the administrative guideline procedures, review every regulation as part of the whole administrative process. They reviewed that one, yes.

Mr. WAXMAN. What kind of conversations have you had with OMB in working out those regulations and administering this program?

Ms. DAVIS. Well, I think they varied over time. There was certainly some evidence that we needed to monitor the program very carefully. We did clarify our tracking mechanisms and tightened up on our monitoring in order to assure that we were not providing for coverage for individual groups that should not have been covered. I think that was an important role.

From time to time, just as we have done in any new policy area, we have involved total administration in review of individual particular situations. But, frankly speaking, over time we have streamlined and monitored our own system, and I believe it is fair to say at this point in time they have a very minimal role.

Mr. WAXMAN. Fair to say—

Ms. DAVIS. They have a very minimal role. Simply that of an oversight of watching what the expenditures are.

Mr. WAXMAN. Has your staff ever received any suggestion from any OMB official regarding questions to be asked of the States in

connection with their waiver applications? Do you know that OMB officials are going out to States like North Carolina, asking them all sorts of questions in connection with this waiver application?

Ms. DAVIS. I didn't know until I was here today that they had visited, but it doesn't surprise me because in the role that they have in terms of overview and oversight of expenditures, I know they have been visiting a lot of different programs. Many times they visit to learn more about the programs. I have heard of times from when they visited fiscal intermediaries or visited several institutions. I think it is part of their learning process.

Mr. WAXMAN. We would like to get for the record from you any documents relating to the respective roles of OMB and HCFA in this program. My last question, because I know other members want to pursue inquiries, and I have others, but I will try to get those to you in writing.

Your March 13 regulations, in effect, cap the States' spending for home and community-based services at the States' estimated cost for those services; yet the statute to achieve budget neutrality only requires the States demonstrate that their spending under the waiver bill not exceed what they would have spent without the waiver. Where do you believe you get the authority to impose an expenditure cap?

Ms. DAVIS. Obviously, we would not have imposed that if our general counsel had not believed it was an appropriate management tool, and we see that as a management tool. Because if we didn't have something like that, it would be very possible for the States to overspend, to disregard either the numbers of individuals—in their initial estimates—as we have already had examples of, or to spend more.

One study for example, estimated they were going to be spending about \$4,000 and they spent in excess of \$12,000 per case. It seems to us that you have to have some kind of effective management tool to keep that from happening, or you won't have a budget neutral situation.

We clearly were charged under the act that the program would be an alternative to institutional care for those who would otherwise have been likely to have been institutionalized, and we won't be spending more on it than we would have otherwise.

Mr. WAXMAN. Perhaps a good management tool would be to put a cap on the Medicaid system. You certainly don't have the authority to do that. What we expected was not to spend more for those individuals who could be deinstitutionalized and put in a community care situation. But to put a cap on it, obviously that is going to discourage treating many of those patients in that kind of setting. How do you respond to that?

Ms. DAVIS. I think it is important to recognize we don't view that specifically as a cap. There is an opportunity to amend plans, if the individual State believes they have further information later on, that either the costs will be more or there will be more individuals they discover would qualify. If they write in and amend their plan, that is fine. We do need to track it. Otherwise we would be held as not being accountable for the management of the program.

I think we could wake up and find that we had a vast new type of coverage of additional groups that were never intended within

the program if we were not managing the program prudently, and my feeling is if we didn't do something to effect some kind of a management of this program, that we could be in an oversight hearing in another couple of years with people very concerned about how well the program was being overseen and managed.

Mr. WAXMAN. You indicated you are going to have an independent evaluation of the 2176 waivers and that the evaluation is already underway. You mentioned the study is scheduled to run through September 1986. When can we in the Congress expect to receive a rigorous analysis, as you phrased it, of the number of beneficiaries served under the waivers, their cost and utilization experience?

Ms. DAVIS. We sent up to Congress just yesterday, the first year's report of program expenditures. That would not be considered to be a rigorous analysis, however, because it contains very limited data based upon early cost reports from only a few States. I believe you probably cannot expect a rigorous analysis for at least another year, until we have further data.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

Dr. Davis, why did it take 4 years to get the final regulations in place?

Ms. DAVIS. Well, we have many, many regulations on our plate, as you well know. Congress sort of yearly gives us a new batch of materials that frankly have to take precedence because we had that one out in an interim final. And while there were some changes made between that and the final, there were many other regulations that we absolutely had to have out in order to make the savings that Congress had estimated in their yearly tax expenditure areas.

Mr. WYDEN. What I have trouble understanding is how this can be a priority program and something the administration feels strongly about, if it takes 4 years to get the rules in place. What we have heard from the State administrators is that not having the regulations was a big part of the problem—the confusion and the uncertainty and back and forth. It just seems to me, for a program the administration says is a real priority, to take 4 years, to have all the back and forth and constant confusion, that is something we have got to turn around.

Ms. DAVIS. I would point out, it only took us 60 days to develop the interim final regulations, and they were interim finals, so they could be implemented immediately. It seems to me that showed our good faith, because we could have lingered long months and had nothing in place. We were equally committed to having something almost immediately.

Mr. WYDEN. Based on everything I have heard from the administrators, essentially this program has been on an interim status for the last 4 years. It has been just constantly changed.

Let me turn to one other point you talked about in your testimony, this question of targeting and your concern about targeting. Now, targeting means the ability of the States to identify individuals who are at risk of needing nursing home care. I think we would all agree we want to zero in on those most at risk. What

problem do you have with the States as far as their approach to targeting?

Ms. DAVIS. I think the targeting varies by State. It is like anything else. We learn as we go along in these various programs. There are a lot of different assessment tools to assess who would have been in need of institutional services, and clearly different States are using different techniques for doing that.

The more important point is that we must be certain that they are actually doing an assessment before they make a determination, and, second, that—

Mr. WYDEN. Are there any States not doing an assessment?

Ms. DAVIS. There are States that do not have assessments—

Mr. WYDEN. Which ones?

Ms. DAVIS. Louisiana and Pennsylvania are two. We, from time to time, as we have done our assessments, go in on a yearly basis and assess the programs, and when we find something like that, we ask for corrective action plans. [See p. 311.] From our point of view, we also found some States where they have failed to inform the beneficiaries they have a right to make a decision for themselves whether to accept services at home or to go into an institution, and we believe that freedom is important to preserve also.

So some of these, as I say, have been an outgrowth of our having done the assessments of the program. I believe both the States and we are learning as we have gone along.

You mentioned earlier, the program appears to have been in some degree of fluctuation. I think that is true. Over time, we have learned more about what is going on in the program, what some of the pitfalls can be. In one particular State, we found examples of where providers were providing services that hadn't been certified to provide those services. Indeed, one individual provider was in jail during the time he was supposed to be providing the services. So I mean there is evidence—only anecdotal—but we have to do something about monitoring those situations.

Mr. WYDEN. I would like to leave the record open for you to respond in the record. You have identified specifically two States where you thought there were abuses, where the efforts to target had not been properly done, and let's leave the record open with respect to others where there are similar problems.

Ms. DAVIS. I would be happy to provide additional information.

[The information can be found in the answer to question 1 of responses to the subcommittee. See p. 295.]

Mr. WYDEN. One other question, if I might.

There has been some discussion that the nursing home bed test, the bed test requirement in the March 13 regulations, in effect, rewards States that have promoted nursing home growth. How would you respond to that?

Ms. DAVIS. Well, again, when we looked at the language in the conference committee report, it seems pretty clear to us we were to be providing services to those individuals that would otherwise have been institutionalized if the State didn't have any beds or they didn't have any possibility of having beds or they had had beds at one point and they were reduced, we could recognize that.

It seems if you never had any beds, then you could suddenly find yourself with a large number of people who obviously wouldn't

have been institutionalized because there wouldn't have been services available for them.

So that became part of our rationale for that. It is important to recognize we try to give the State as much flexibility in that area as possible. We not only count current beds, we also say to them, "If you deinstitutionalize and close beds, we will recognize that."

Mr. WYDEN. It seems to me there is a lot more less-burdensome way to identify people at risk of institutional care and still meet the cost neutrality guidelines. For example, I know in Virginia they are using medical and social assessments need for nursing home care.

Ms. DAVIS. They have a tightly controlled system, and we believe that is a very good model.

Mr. WYDEN. If other States were to look at these kinds of approaches, would you be willing to consider that as an alternative to your proposal in the March 13 regulations?

Ms. DAVIS. Although we think what the State of Virginia has done is a very fine example of targeting, I don't think that we believe any one assessment is yet developed that we would say is the perfect tool. I think there would be resentment if we were to mandate one specific tool in that area.

Mr. WYDEN. My time has expired. One last comment, if I might, Dr. Davis. It seems to me that everything the President has said in the health care field has been based on the idea we should encourage experimentation, and we should encourage development of new approaches and new technologies. I think that that is absolutely right, I think we should go slow on setting up new programs that we can't suddenly go back and unravel.

But everything that I see about what has happened in the last 4 years, and we have been on the phone constantly with our State, has been that a program that would give us a chance to experiment and try new things has been put in a straightjacket and it has limited our ability to experiment and try new things. In that way, I think the President has been very poorly served with the way that this program has been administered in the last 4 years, because I think that is not what he has wanted.

I hope we can work with you now and come up with another approach, and that we can get backing in both parties to get this on track because I think we have really gone astray.

Mr. WAXMAN. Mr. Tauke.

Mr. TAUKE. Thank you, Mr. Chairman.

Dr. Davis, relating to the Office of Management and Budget and its role in the program, does the Office of Management and Budget consider individual waiver applications that are placed before HCFA?

Ms. DAVIS. No; as I mentioned earlier, that is under our authority to do that. We do send a report to them once a month.

Mr. TAUKE. Do they have the ability to deny or do they ever deny waivers?

Ms. DAVIS. They do not, nor have they ever denied. For a period of time, we did get input from them concurrently while we were doing our review in terms of the give-and-take of the review process. At all points in time, the final authority has been ours. The Secretary has authority in this. It has been delegated to me.

Mr. TAUKE. State administrators indicated they have the same financial concerns the Federal Government has. For every dollar the Federal Government would lose, the States also have to put in money, and they have to be accountable to State legislatures and so on, and, therefore, the concerns the States were going to abuse the program just were unfounded.

How do you respond to that assertion?

Ms. DAVIS. I believe there are different levels of oversight in different States. Clearly some of the States have done a fine job. Other States we have assessed had significant problems. It is a great problem for us when we get actual cost expenditures at the end of the year which have had to be revised three times. It makes us wonder how fiscally responsible they really are.

I think, as I said earlier, some of the procedures that we have come up with have been as a result of experience that we have had with the program. And one develops monitoring and oversight in response to those situations in order to protect the integrity of the program.

Mr. TAUKE. You alluded to some quality of care problems in some of the programs. Could you tell us a little more about the quality of care you have found in some of the waiver programs?

Ms. DAVIS. I think in general, again the quality of the care has been good, but it is like anything else, sometimes I believe that in an effort for the State to get the program up and going immediately, they have failed to certify the procedures, and so we found ourselves with payment for services when providers were not actually certified to provide the services. In some cases it was done retroactively. In other cases, we had some significant problems of questioning why individual providers were considered to be deemed in the program.

I used the example in one State, one provider who was in jail during a period of time they were allegedly providing services. I am not quite certain how that happened, unless we have a new school of rehabilitation in the corrective systems.

We had another situation in which a provider had disabled clients on an upper floor of the facility, and it didn't have a functioning elevator. It is difficult to see how you can establish humane quality of care if you are denying them access to what we consider the environment in general.

We have had a situation where again clients have been placed in unlicensed facilities and somewhat coerced, if you will, into accepting the fact that they had to elect certain services. They weren't provided with a plan of care.

So those are some of the situations that we have seen. They are anecdotal, but I think it is important to recognize that those are the signs and symptoms that you see in any beginning program. Once the program gets up and established, it seems to be developed more effectively, and there is more State oversight at that point in time.

Mr. TAUKE. You heard the comments from the State administrators about difficulty in knowing what HCFA wants from them. Information is requested and then there are changes in the request. Certainly there must be some way to be able to iron out that problem.

Ms. DAVIS. Well, I would hope there is. We have tried on a couple of occasions to send out guidelines. We are going to try again. I mentioned earlier, when we have a State Medicaid directors' meeting—I can't remember a meeting we have had since 1981—that we have not had a session devoted to the technical discussions of how to handle processing of home and community-based waivers.

Bob, you might want to respond to some of that.

Mr. WREN. We have tried to provide the States with a copy of the review document that we actually use in reviewing the waiver requests. We have trained our regions, we have trained our people in the States, and we have made numerous trips to the States to help them piece together a waiver request. As Dr. Davis pointed out, we are in the process now of redeveloping a review document for the States to use.

With respect to the model waiver, we have actually given them a preprinted form that is really a fill-in-the-blanks checkoff item to help facilitate the waiver requests.

Ms. DAVIS. I would like to point out there are occasions when the staff provided a very expedited review. I am reminded of an example where New Jersey asked us for expedited review of a single individual who was going to be qualified under the Model Waiver Program, and we did that expedited review within a 1-day time-frame to allow that woman, who had Lou Gehrig's disease, to be deinstitutionalized and be at home with her family. We have tried to exercise oversight, but with compassion.

Mr. TAUKE. Thank you, Dr. Davis, Mr. Chairman.

Mr. WALGREN [presiding]. Dr. Davis, as I understand, in Allegheny County, the application for a program, which was relevant to one of the witnesses in the panel of individuals who came forward, was to attempt to deinstitutionalize a number of severely disabled but mentally alert individuals from intermediate care and skilled nursing care facilities where they clearly are inappropriately placed, in that they tend to be relatively young people, and most of the individuals in the institutions are elderly, at least.

As I understand it, that project is relatively unique in that most of the applications for waiver are for the mentally retarded or the elderly directly.

Ms. DAVIS. That is correct.

Mr. WALGREN. I think it is particularly a shame that the application has not been approved because these individuals seem to be certainly the first and foremost ones that are inappropriate in that kind of facility and whose lives are genuinely frustrated by having that kind of facility be their only recourse.

As I understand it, there were several points that were objected to. The first is that the Federal level asks that the reference in terms of cost be a statewide average of patients in a similar facility. Now, the problem obviously being that we were asking them to compare young people with elderly people, and the elderly people, because they did not last in the facility that long and in fact had an expiration date 200 days through the year, a cap was essentially put on the possibility of considering the cost in these instances because of a comparison that was not a like population.

Is it your view that in implementing this waiver, we should be looking for truly like populations so that we can make an accurate cost estimate so that the full services can be provided?

Ms. DAVIS. I think clearly the issue of what is budget neutral is going to be important for us. But I would just like to point out in terms of clarification, we asked the States for further information to help clarify some of the questions we had, and you pointed out some of those questions. We had a number of various questions. We asked them for additional information last September. We have not heard anything back from them since then. We did offer to meet and provide technical assistance. Nobody has taken us up on that. It seems like it is sort of dormant someplace.

Mr. WALGREN. We will certainly take you up in pursuit of that. It is my understanding we are now a year into that and that there was now a denial rather than a request for further information.

Mr. WREN. Mr. Walgren, we have not denied that. And while we have a 90-day time period, once we formally request additional information, the State does not have a similar timeframe within which to work, and we have been more than happy to meet—in fact, made the offer to meet with the people in Allegheny County to tell them how to figure the waiver so it would improve their chances.

Mr. WALGREN. Am I operating under the right assumption, we are looking here for the cost of like individuals, and like individuals are not the per capita average of an elderly population not receiving services for a full year. Like individuals obviously are individuals that are at least in the institution for a full year and that the cost that we would be looking for would, therefore, be based on that subset of the population.

Mr. WREN. It is my recollection the problem was not so much like populations, but the State had—or whoever had developed this waiver—had misunderstood what was required for the formula in both the second and third years of the waiver. We would be happy to explain that to them.

Mr. WALGREN. I certainly want to pursue that with you.

The other reservation that apparently caused a problem was that it was asked that the State be held to statewide aggregate costs. Now, our State has some institutions in the rural areas that don't have the costs that the institutions in the urban areas have. Inasmuch as we are in Allegheny County focused on a relatively high-cost area, I had thought the intent of this waiver was if we could enable somebody to be deinstitutionalized at less cost, we were prepared to do that. We obviously are not going to do that if we define less cost as something on an aggregate that does not apply to the population area that the individual is trapped within.

So it would seem to me that if you understand it as I do, that we are after the actual individual cost that we would be saving in order to allow the release of somebody from such confinement, then I would feel that you were implementing the intent of Congress. But if you are looking for larger averages that mean there are some people who are incurring higher costs presently to us and we are unwilling to release them because we are unwilling to provide support at that previous cost level, then we in a sense are

trapping them in that circumstance and not enabling them to be released.

Mr. WREN. I would point out to you Allegheny County already has one approved waiver, and in developing that, they used aggregate cost. I have a suspicion that what is involved is a misunderstanding as to what is required. I think we can get together and explain perhaps what we have in mind.

Mr. WALGREN. Then the other more generic problem is this, particularly these instances of several disabled young adults. We need support for some kinds of vocational and other kinds of habilitative services. As I heard your testimony, Dr. Davis, you specifically felt that we could not go that far and that the March 13th regulation apparently prohibits in direct terms the use of Federal funds for pre-vocational, vocational services. That is my understanding of the statute, that the statute does not entail such a prohibition and, in fact, has the positive command that we provide habilitation and other services provided by the State if we are staying within a cost effective change in that person's circumstance.

Our purpose, as I understand it, we are required by law to provide a full range of services if by doing so we save some funds to the program that are now being expended and at the same time capture the magic from release of institutionalization. Could you clarify how your interpretation prohibiting any such services is consistent with the law?

Ms. DAVIS. I think from the beginning of the Medicaid Program, it has been quite clear that Medicaid has never paid for vocational services or prevocational services. Our exclusion was based on that principle. If you look at the kind of educational type services that are provided, there are indeed other Federal funding sources and some State sources that do provide those kinds of services. We do not believe that the waiver services that we were to provide would cover those, because it seems to us that our services were necessary to avoid institutionalization. While most vocational services would be valuable, it seemed to us it would be very difficult to establish, if you didn't have those services, that the client would require institutional care.

I think it was a combination of those two activities. We do have a technical advisory group of individuals from the Medicaid Program that we are constituting to look at a number of issues as they are devoted to the home and community-based service area, primarily with respect to the mentally retarded. And one of those is going to be trying to look at what should be the appropriate definition of vocational services. That group is meeting June 27th. I guess that is in the next couple of days.

Mr. WALGREN. That won't be limited to mentally retarded in any way. They are no different than anybody else.

Ms. DAVIS. They are a group we have seen use the vocational type services. It was an outgrowth of our work in that particular area.

Mr. WALGREN. I guess what concerns me is that some kinds of waivers may develop an acceptance within your personnel that then another group that may not be mentally retarded would trigger some kind of rejection.

Ms. DAVIS. I don't believe so. I think if we found a definition that is functional for the Medicaid Program, we would apply it across all of the groups.

Mr. WALGREN. You don't deny that you have the authority to go beyond the present—or the traditional services covered under Medicaid in implementing this waiver program. The statute gives you authority to provide more than the services which you—

Ms. DAVIS. Yes. Providing they are necessary to avoid institutionalization. I think the clear-cut decision would be which services would be necessary to avoid institutionalization and which services, although they might be desirable, wouldn't necessarily prevent or avoid institutionalization. It is an area our general counsel and us have spent a great deal of time discussing.

Mr. WALGREN. That is an interesting distinction. My own wish is that if you keep your eye on the intent of the statute, which is truly focused on allowing people to not be institutionalized, I read the Congress as saying in that law, particularly when they provide for habilitation and other services requested by the State, not limited to the traditional Medicaid services, and when the report provided specifically that such services would be encompassing both health and social services needed to insure optimal functioning—now, at that point, the law, as signed by the President, it seems to me, is directing you to go beyond simply the services necessary to enable even deinstitutionalization. It is directing you to insure optimal functioning.

Now, that may be something that is a substantial broadening of your past tradition, but it is the law, and it is the law because our purpose is to—is if it was cost neutral to the Medicaid Program, we were willing to give these people a chance to be out of the institution, and it didn't have to be maximally cost effective, it only had to be less cost or not added cost. In that sense, any failure to develop this program along those lines is contrary to the law.

Ms. DAVIS. Well, again, I would point out that we have given high priority toward clarifying that particular policy. We have a group coming in in a couple days' time to try to discern what is truly vocational and what is pre-vocational and what is educational. I think there are many individuals who work with these areas who would tell you that that area is cloudy at best.

Mr. WALGREN. Would that group have been asked to also define what would insure optimal functioning? Because that is what the law is. The law isn't written in terms of vocational, prevocational and those sort of things.

Ms. DAVIS. May I point out too, sir, the law also says optimal functioning is a part of it, but we would be paying for services intended as an alternative to institutional care for persons likely to be institutionalized.

Now, when you begin to examine, would those services have been provided to that same individual in an institution, that is where the cloudy part comes in on that particular issue.

Mr. WALGREN. My own reaction is—and I am not an expert in this—but I think that is irrelevant to the law. I think the intent of the law is that if it is not going to cost you any more money, you ought to do it, because you can get these people out of the institu-

tions and that it really doesn't matter whether they would have gotten those services in the institution or not.

What President Reagan was concerned about was that Katie was in an institution. He didn't stop to concern himself with whether or not she got "X" services or "Y" services in that institution; he wanted her out, and he had a right to want her out, and the Congress and the law backs that up.

And I would hope that as you develop this, that you be as creative as you possibly can, because the law is there to support you. I know all of us are sensitive to cost constraints, but they must be read within the intent of the law. We have given you your mark. Below that, your attention shifts to freeing the person from the institution, and it goes right by without noticing some of these traditional services, would it have been provided or not? That is all not considered in the use of the law. Inasmuch as your obligation is to give accurate and full life to the law, that is what you are sworn and obligated to the public to implement. I hope you can approach that in a creative way, as you do give life to this program.

You deserve the last word, and I would be willing to have you have it.

Ms. DAVIS. We will take your remarks under consideration as we work with the group.

Mr. WALGREN. All right. With that—I do want to emphasize on behalf of the chairman, who had to go, as is obvious from the testimony, that we feel that this law has not been implemented the way it clearly on its face requires and that we want to send a very clear message to OMB we are not out here to break the bank, but we are here to implement the law and that if the law is not given the life that it obviously has in its intent and on its face, we are going to be trying to legislate those services to the fullest, and I do believe that it is even in OMB's interest to not be obstructionist in this area, and certainly your clear fiduciary obligation to very dependent people is to give it the direct life that is stated in the law.

So we want to work with you in that process, and you know that you, in particular, have all our respect in the way that you have addressed questions raised with HCFA. We want to work with you to make this happen.

Ms. DAVIS. Thank you.

Mr. WALGREN. Thank you, Dr. Davis.

That then concludes the hearing.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned subject to the call of the Chair.]

[The following statements and letters were submitted for the record:]



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

August 9, 1985

The Honorable Henry A. Waxman
Chairman
Subcommittee on Health and the Environment
Committee on Energy and Commerce
House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

This responds to your request for information subsequent to the Subcommittee's June 25, 1985 hearing on the Medicaid Home and Community-Based Waiver Program. The edited transcript of my testimony and an insertion for the record that answers Representative Wyden's request for information on specific State abuses are being forwarded separately.

I was pleased to be able to testify before the Subcommittee on this very important program. However, I would like to correct a misconception that was made apparent during the hearing and is evident yet in your letter's closing comment. We have a documented record of providing substantial technical assistance, open access, and equitable treatment under the waiver program. As I testified, we estimate that 200 HCFA staff hours are spent in reviewing each initial waiver application and about 300 hours on each renewal request. I have a high regard for the professionalism of the staff who monitor the waiver program and believe that without their dedicated efforts, fewer waivers would have been technically qualified for approval.

Thank you for the opportunity to respond to these questions. Please let me know if we can be of further assistance.

Sincerely yours,

Carolyn K. Davis, Ph. D.
Administrator

Enclosures

Responses to Questions Submitted by the Subcommittee on
Health and the Environment, Subsequent to the June 25, 1985 Hearing
on the Medicaid Home and Community-Based Waiver Program

- 1.Q. At the hearing, you testified that a number of States have engaged in practices inconsistent with the terms of their 2176 waivers. For each instance of which the Department is aware, please: (1) identify the State and the waiver involved; (2) describe the State action at issue; (3) explain why the State action constitutes a violation of the 2176 waiver statute or regulations; (4) describe the actions which HCFA took to correct the State's activities; and (5) describe the actions the State took to correct the violations.
- A. At the outset, I would assure you that in the majority of cases, we believe the States are using the waiver program as an innovative, welcomed alternative approach to high cost Medicaid institutional care. Regrettably, there are a few exceptions. I also point out that HCFA conducts an annual assessment of each waiver program to determine compliance with statutory and regulatory requirements. It is quite common to find one or more areas in which any waiver program is out of compliance. These deficiencies are generally resolved promptly through a corrective action plan developed by the State and approved by HCFA. Therefore, I will highlight only those situations in which HCFA's findings were particularly serious.
- o Several States have significantly exceeded the number of persons or costs which they had projected when HCFA approved their proposals. Such excesses may result in a situation where the waiver program would cost more than would otherwise have been the case in the absence of a waiver.
 - + One State (Florida waiver for the mentally retarded) received approval of a waiver to serve 3,500 recipients and actually provided services to over 7,000 clients. The additional clients would not have received services in a skilled nursing facility or intermediate care facility absent the waiver. As such, they constituted additional cost to the Medicaid program of over 3 million dollars. The inclusion of these clients was contrary to sections 1915(c)(2)(C) and (D) of the Act and 42 CFR 441.302(c) and (e). The clients were not at risk of institutionalization and their inclusion in cost estimates, as if they would have been institutionalized, rendered these estimates invalid and unreasonable. After HCFA advised the State of this problem, Florida rectified this problem by agreeing to reduce the size of its waiver program over a 16-month period by transferring less impaired clients to State funded programs.

- + Another State (Vermont waiver for the mentally retarded and mentally ill) used a waiver to provide services to several hundred persons who had been satisfactorily treated in outpatient clinics before the waiver. The costs to serve these clients under the waiver constituted additional Medicaid expenditures. Since these clients were not at risk of nursing home placement, the provisions of section 1915(c)(2)(C) of the Act and 42 CFR 441.322(c) were compromised.

Data provided by the State on the first year of its program reflected a lack of cost effectiveness attributable to this population, in part, violating section 1915(c)(2)(D) of the Act and 42 CFR 441.302(e). After HCFA advised the State of this problem, Vermont agreed to eliminate these clients from its program and provide services to them in the community through the outpatient clinic services which had previously provided care.

- + A State (Louisiana waiver for the mentally retarded) also converted a State funded sheltered workshops program into the waiver in an attempt to refinance this program under Medicaid. The majority of the clients in this program would never have incurred a Medicaid institutional cost and as such constituted additional costs for the program. This practice violated the same provisions cited above. After advising the State of our concerns several times over an 18-month period, the State consistently refused to address this and other deficiencies in its waiver. HCFA denied the State's request to continue this waiver program when it expired in January, 1985.
- o Some States have improperly administered their programs in ways which could adversely impact the health and safety of recipients.
 - + One State (West Virginia waiver for the aged, disabled and mentally retarded) allowed both individual and institutional providers of service into its program which could not be considered to safely and effectively deliver services. For example, it housed clients in a building that was unsanitary and unsuitable for providing safe and adequate services. There were insufficient staff to cover minimal daily needs and untrained staff performed medical-type duties. The building's set-up precluded safe access to dining facilities and proper egress in case of emergency. In addition, one individual provider was in jail during a period of time he was being paid by the State to provide waiver services. This is in violation of section 1915(c)(2)(A) of the Act and 42 CFR 441.302(a). The State was made aware of our concerns with this as well as many other aspects of its waiver program over a 2-year period of HCFA monitoring. The State failed to correct the problems. HCFA denied the State's renewal request in June, 1985.
 - + Another State (Pennsylvania waiver for mentally retarded in Philadelphia County) placed clients in unlicensed facilities, failed to offer mentally incapable clients or their parents the required choice of waiver vs non-waiver services and did not provide services under a plan of care. This violated the health and welfare provisions cited above as well as the freedom of choice requirements of section 1915(c)(2)(C) of the Act and regulations at 42 CFR 441.302(d). The State's request for additional waivers of this type was denied. The State submitted an acceptable plan of correction and HCFA has recently reassessed the program. We believe the State is now in substantial compliance and additional waiver programs will be considered.

- 2.Q. In a memorandum dated August 8, 1984, to Mr. Joseph R. Wright, Deputy Director, Office of Management and Budget, John J. O'Shaughnessy, Assistant Secretary for Management and Budget at HHS, stated that "HHS adopts in full the recommendations of the report attached at Tab A." The relevant pages of this report, entitled "Report on OS Review of HCFA Waiver Process," are attached for your convenience.
- a. This report states that "OS and HCFA staff have met with OMB to discuss a draft list of the criteria to be utilized in analyzing these waivers and have reached agreement." Please provide a copy of this draft list.
 - A. Attached is the draft list of criteria which we discussed with OMB last year. Please note that this was a draft working document at the time and subsequently underwent substantial revisions.
 - b. This report states that "With the exception of time frames, both the home and community-based service and freedom of choice waivers will be subject to the same review process described in the research waiver section. Due to the statutory requirement to act on the waivers within 90 days, OS should be notified on day 70 with OMB notification on day 75 of the HCFA (90-day) review period." Does this accurately characterize the current OMB review process for the 2176 waivers? If not, in what respects does the current OMB review activity differ?
 - A. This schedule characterized the OS and OMB review process up until several months ago. Both OS and OMB reviewed home and community-based waivers with total gross costs over \$1 million. The review focused on the criteria used for analysis of the waivers, such as: analysis of estimated expenditures with and without the waiver, risk of institutionalization, and scrutiny of bed supply indicators. Neither ASMB or OMB are now involved in the current home and community-based waiver review process. Since the waiver program has been operational for several years now and the final regulations for the program are in place, it was felt that this level of review was no longer necessary. HCFA does prepare a monthly report on waivers which have been approved, disapproved, or withdrawn, and this report is made available to ASMB and OMB.
 - c. Please provide the subcommittee with any documents, other than the August 8, 1984, O'Shaughnessy memorandum, which set forth the respective roles of OMB and HCFA in the administration of the the 2176 waivers, including the provision of technical assistance, the review of applications for waivers or renewals, the evaluation of waivers, and policy development.
 - A. The issue of the respective roles of the Department and EOMB over the 2176 waiver process has been resolved. The Department is solely responsible for the administration and oversight of the waiver program.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

August 8, 1984

Memorandum

To: Mr. Joseph R. Wright
Deputy Director
Office of Management and Budget

From: Mr. John J. O'Shaughnessy
Assistant Secretary for
Management and Budget

The following material related to the improved management of Medicare and Medicaid waivers is provided for your information. Attached to this memorandum is a listing of those waivers, excluding ones for Home and Community Based Services and Freedom of Choice in the Medicaid program.

As you are well aware, HHS believes that these waivers have proven to be most beneficial in introducing flexibility into the delivery of services and providing sufficient information on which to base program improvements. However, HHS has over time attempted to improve the management of this process. In line with such efforts, we asked a group of senior executive civil servants to look into the management processes covering Medicare and Medicaid waivers and to recommend improvements. (See Tab A for a copy of their report.)

HHS adopts in full the recommendations of the report attached at Tab A. Many of these initiatives were in fact originally proposed by HCFA. HCFA will submit its recommendation to the Office of the Secretary on the task force recommendations by August 31, 1984 or the date mentioned in the report, whichever is later. HHS will inform OMB of its decisions on those recommendations two weeks after the HCFA submission. You should note that in the case of developing costing methodologies, HHS will submit its proposals for developing those systems by October 15, 1984. It may take three months or longer to implement those systems fully. In the meantime, however, HHS will insure that cost estimates for projects are reviewed, and agreed upon, by the budget offices within HCFA and OS, and that we report to you consistent with current apportionment guidelines. Finally, one point should be added to the management recommendations contained in the attached report. That is, there should be an annual evaluation within the Department of the experience with the waivers against the overall plan in effect.

TAB A



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

Memorandum to: John J. O'Shaughnessy

From : Tony Itteilag
Bryan Mitchell
Robert Sermier
Michael Sturman
Robert Trachtenberg

Subject : Report on OS Review of HCFA Waiver
Process

At your request, we have completed a review of the HCFA waiver process, including waivers awarded under both research and program authorities. We interviewed senior level program and policy officials in HCFA, OS, and OMB.

This report contains a brief description of the current waiver process followed by a findings and recommendation section. As research and policy waivers are treated uniquely within HCFA, they are described separately in this report.

As a result of the limited time within which both the HCFA and OS reviews were conducted, we have recommended that further consideration be given to the specifics of the revised process which HCFA proposes (with OS involvement where appropriate) and have outlined a series of steps which HCFA should take before finalizing the details of the revised process. We believe that a revised process should be agreed to within the Department and by OMB.

Attachments (2)

4. OS and OMB Review

- o Another key issue to be addressed in order to stabilize the research waiver process involves the nature of review by entities outside HCFA. Since November 1981, the Department has received numerous written communications, including apportionment footnotes, from OMB which have attempted to define the review process. We propose the following which would supersede these communications insofar as they apply to research waivers:
 - In general, HCFA should notify OS 40 days in advance of all new waiver projects involving total gross costs over \$1 million prior to HCFA approval. Expansion of existing projects which would involve additional gross costs of over \$1 million will be considered a new project. OS staff will review but will not approve or disapprove projects. Any issues raised by OS staff which cannot be resolved at the staff level will be raised to the Secretary for final approval/disapproval.
 - Consistent with the current apportionment requirement, and within the 40 days set forth above, ASMB will notify OMB 30 days in advance of any waiver project involving gross costs over \$1 million. These projects will be submitted for OMB review only. Any issues identified by OMB will be raised by the Director to the Secretary.
 - In unusual circumstances, HCFA, OS and OMB may agree to a review period of less or more than 40 days.
 - For all other projects, HCFA will inform OS of approval promptly (within 10 days after approval), providing sufficient information justifying gross costs of a level of \$1 million or less. If disagreements arise over the estimates, the matter will be raised to the Secretarial level for consideration of a revised review process.
 - ASMB, in consultation with HCFA and OMB, will develop, based on previous similar efforts, a standard form which contains the relevant project information in order to facilitate review. This form should be developed by September 1.

8. Implementation of Revised Waiver Process

- o With regard to all projects which HCFA believes must be acted on prior to implementation of the revised process, HCFA should notify OS, within two weeks, of what projects are currently in the pipeline, their status, cost information and the key issues which must be addressed for each of the projects.
- o For each of the tasks assigned above, HCFA needs to provide an implementation schedule which includes milestones and completion dates.
- o In addition, ASMB will periodically review HCFA's progress in implementing the revised waiver process beginning October 1.

HCFA Policy Waivers

Background

The HCFA report did not address the Medicaid policy (i.e. home and community-based service and freedom of choice waivers) waivers. These waivers are the responsibility of the Bureau of Eligibility, Reimbursement, and Coverage (BERC) under the Associate Administrator for Policy.

These waivers were authorized by the 1981 Omnibus Reconciliation Act and are designed to provide States with greater flexibility and the ability to test new approaches in the delivery of Medicaid services. Unlike the research waivers, HCFA is required by statute to deny the waiver within 90 days or it is deemed approved. HCFA may, however, request additional information, in which case they have an additional 90 days before having to approve or deny the waiver.

As of June 30, 44 States had 76 approved home and community-based service waivers. Sixteen States had 39 approved freedom of choice waivers.

Pursuant to the statute, home and community-based service waivers are awarded for a three-year period and freedom of choice waivers are awarded for a two-year period. These waivers are currently being submitted to OMB for an agreed-upon 10 day review period on day 75 of the (90 day) HCFA review period.

Description of Review Process

The home and community-based service waivers receive a greater degree of scrutiny than research waivers. Services which may be provided under the waiver include adult day care, respite care, and homemaker services. States are required to submit estimates of costs and recipients and must ensure that per capita costs

under the waiver will not exceed per capita costs without the waiver. HCFA verifies the estimates by comparing them to data contained in annual statistical reports submitted by the States as part of the normal Medicaid reporting requirements and by examining the current levels and trends in certified long-term care beds.

In addition, States are required to submit annual reports on numbers of recipients and expenditures for both waived and acute care services. Waiver expenditures are also identified on routine expenditure reports submitted by the States on a quarterly basis. The regional offices conduct on-site monitoring of the project and are involved in the initial review of the project. The waivers are approved by the Administrator and disapprovals are submitted to the Secretary.

The final regulation currently pending at OMB would limit federal matching for waived services to the estimates contained in the waiver application. In addition, it would require that aggregate expenditures under the waiver, both for waived and acute care services, not exceed aggregate expenditures without the waiver.

The freedom of choice waivers undergo considerably less scrutiny and tracking. The majority of these waivers involve a case management approach or the coverage of additional services for HMO enrollees. States are required to submit documentation of the cost-effectiveness of the project and the projected impact on recipients. HCFA then reviews and evaluates the data submitted by the States. Given the variability of these projects, there are no standard data or reporting requirements. The waivers are reviewed by the regional offices and as well as other HCFA staff with relevant expertise. These waivers must also be approved by the Administrator.

Findings and Recommendations

Unlike the research waivers, OMB's concerns over the home and community-based service waivers focus on statutory intent and requirements rather than the review process itself.

OMB staff believe that these waivers should focus on deinstitutionalizing current nursing home beneficiaries rather than deterring institutionalization. In those cases where the waiver attempts to deter institutionalization, OMB believes greater emphasis should be placed on ensuring that the individuals receiving waived services would otherwise have been institutionalized. This would be accomplished by securing verification of future bed supply estimates (e.g. State appropriations, certificate of need approvals, etc). In

addition, OMB wants us to consider ways of better ensuring that Medicaid costs under the waiver are no more than they would have been in the absence of the waiver and that State projections of expenditures are not exceeded. All parties are now in agreement that, under the statute, only Medicaid costs can and will be included when determining if a waiver is cost-effective (i.e., AFDC, SSI, Food Stamps, etc., will not be included).

This issue has been addressed by first establishing, in consultation with the Office of General Counsel what may or may not be considered in evaluating a waiver request in accordance with the statute and congressional intent. OS and HCFA staff have met with OMB to discuss a draft list of the criteria to be utilized in analyzing these waivers and have reached agreement. In general, the revised criteria will result in a strengthening of our analysis of whether individuals are at risk of institutionalization, through, for example, greater scrutiny of assessment instruments and future bed supply indicators, as well as ensuring that expenditures under the waiver do not exceed expenditures in the absence of the waiver.

OMB has not had an opportunity to review any freedom of choice waivers, and therefore we have received no feedback on their concerns in this area. We believe, however, that several improvements can be made in the review and tracking of these waivers. While we recognize that States have as great an incentive in ensuring that these waivers do not result in net costs as does the Federal government, there is always the potential for a project to result in an unintended increase in expenditures. Therefore, we recommend that HCFA staff more closely review the cost estimates and assumptions submitted by the States. Furthermore, HCFA should require the States to separately identify waiver expenditures on the routine expenditure reports in order to more carefully monitor waiver expenditures. HCFA should report to the Secretary, by September 15, a strategy for tracking these expenditures.

With the exception of the time frames, both the home and community-based service and freedom of choice waivers will be subject to the same review process described in the research waiver section. Due to the statutory requirement to act on waivers within 90 days, OS should be notified on day 70 with OMB notification on day 75 of the HCFA (90 day) review period.

DRAFT

1915(c) Waiver Policy

Home and Community Based Services

I. Principles

- A. 1915(c) home and community-based waivers must result in aggregate Federal savings.
- B. 1915(c) waivers do not expand overall Medicaid capacity: 1915(c) waiver care substitutes for funded Medicaid certified ICF/SNF capacity.
- C. Renewable 1915(c) waivers are appropriate only when, absent the waiver, state financing of the home and community services would not be cost effective.
- D. One-time transition 1915(c) waivers may be appropriate when States would save money absent the waiver. The waiver could be encouraged through transition funding.

II. Implementation

- A. For a fixed, identified waiver population, total (all program) Federal costs under the waiver must not exceed costs for this population had the waiver not been granted.
- B. The 1915(c) waiver program must expand neither funded, Medicaid certified ICF/SNF capacity nor its Medicaid utilization.
- C. For 1915(c) waivers the Federal Government will match (at existing FFP rates) the costs of services beyond those in the State plan as permitted by sec. 1915(c).
- D. For transition waivers, the Federal Government will pay 75% of the added services costs in the first year of the waiver program, 50% in the second year, and 25% in the third year.

III. Conditions

- A. Separate proposals must be submitted for each target group (aged, MR, etc.) and each strategy (deinstitutionalization, diversion, etc).
- B. Maximum FFP limit for the institutionalized portion of the target group must be stated in the waiver request.
- C. State must fund and arrange an independent annual audit, which is eligible for normal (50%) administrative match.
- D. Renewable waivers must have completed evaluation data by 28th month of waiver.

d. Please describe the role of OMB in reviewing your response to the inquiries contained in this letter. Identify any changes made in your response at the insistence or suggestion of OMB.

A. EOMB has not reviewed our responses to the inquiries contained in your letter.

3.Q. At the hearing, Ms. Matula, the Director of the North Carolina Medicaid program, testified that, this past February, officials from HCFA told her that, as a condition of approval of the State's 2176 waiver application, the estimated costs for the waiver could not exceed 75 percent of the cost of nursing home care. This "75 percent" guideline does not appear in either the text of, or preamble to, the March 13 regulations.

a. What precisely is this "75 percent" guideline, and how does HCFA apply it to the State waiver applications?

A. The "75 percent guideline" refers to an informal rule-of-thumb used by analysts in evaluating waiver applications. Since waiver services are substituted for institutional services but waiver services may not include room and board costs, it is normal for waiver services to cost less than 75 percent of the cost of institution services, given that at least 25 percent of the cost of institutional care is generally attributable to room and board. HCFA has approved waiver programs where waiver cost exceeds this 75 percent criterion when the State has demonstrated a sound basis for the high costs of its waiver program. States are not in any way constrained by this 75 percent review criterion; it merely signals a need to better justify costs.

b. What is the statutory basis for this guideline?

A. The 75 percent criterion is merely a review tool. It is, of course, based on the statutory requirement in 1915(c)(2)(D) that State expenditure proposals be "reasonable estimates" (emphasis added).

c. What is the policy rationale for this guideline?

A. The rationale for this criterion is discussed in (a) above, and is born of the necessity for us to be prudent managers of this Federal program. Such screens are useful tools to ensure our accountability when administering public trusts.

d. When was this guideline first applied, and to how many waiver applications has it been applied?

A. The 75 percent criterion has been used by HCFA since 1982 and applied to all waivers. As discussed, it is not an absolute limitation but only a reviewer's rule of thumb criterion.

e. Was this guideline suggested or developed, in whole or in part, by OMB?

A. EOMB had no part in suggesting the use of the 75 percent criterion.

4.Q. At the hearing, Ms. Kurland, who heads New Jersey's Office of Home Care Programs, testified that HCFA has told her State that if an individual who is covered under a 50 person "model" waiver enters a nursing home or dies, then that individual's "slot" may not be filled by another otherwise qualified individual until the following contract year. Again, this policy is not articulated in either the text of, or preamble to, the March 13 regulations.

a. What precisely is this "no replacement" policy?

A. The "no replacement" policy is simply a reflection of the recipient counting method used uniformly in all section 1915(c) waivers. Because the waiver statute and regulations require cost computations which are based on annual costs for individuals, we require all waiver proposals to be submitted in terms of unduplicated recipient counts rather than slots, average daily census, or other methods which States may propose to account for waiver expenditures. Therefore, when a State requests and receives approval, as did New Jersey, for 50 individuals, the waiver is limited to 50 unduplicated recipients.

b. What is the statutory basis for this policy?

A. The statutory basis for this policy is section 1915(C)(2)(D), which requires cost neutrality that is calculated in terms of annual expenditures per individual.

c. What is the policy rationale for this policy?

A. The rationale for the "no replacement" policy is that a State negotiates and receives approval of its waiver for a set number of individuals. When a waiver has served the total number of individuals approved in a year, the State cannot replace individuals without exceeding the number approved under the waiver. The State may, however, request an additional model waiver.

d. When was this policy first applied to "model" waivers?

A. This policy has been applied to section 2176 waivers since 1982 when it became apparent that consistency with the statute required a uniform method of counting individuals.

e. Is this policy, or some variant thereof, also applied to regular 2176 waivers?

A. The policy is equally applicable to all waivers under section 1915(c).

f. Was this policy suggested or developed, in whole or in part, by OMB?

A. EOMB had no part in suggesting or developing this policy.

5.Q. Does HCFA, in the course of reviewing 2176 waiver applications, or in monitoring approved 2176 waivers (including "model" waivers), apply any guidelines, standards, criteria, or policies, such as the "75 percent" rule referenced in question #3 or the "non-replacement" policy referenced in question #4, that are not made explicit in the text of the March 13 regulations? If so, please provide, with respect to each such guideline, standard, or criterion, an explanation of:

- a. The content;
 - b. The statutory basis;
 - c. The policy rationale;
 - d. The date it was first applied, and the number of waiver applications to which it has been applied; and
 - e. The role of OMB in developing the guideline.
- A. The scope of this question makes it impossible to respond in detail. Because we have given such flexibility to States in proposing waiver programs, each proposal presents new ideas and analytical questions. Our March 13, 1985 regulations provided background on many of the issues and questions which have arisen in the course of reviewing over 160 unique waiver applications. We believe it impossible and unwise to implement this program with a long list of absolute rules. We have attempted to preserve flexibility for the States under the existing rules while providing HCFA with enough information to make a judgement on the consistency of each waiver proposal with statutory and regulatory requirements. We believe that enumerating all the issues that have arisen in 160 waiver programs would not only be impossible, but would tend to curtail the creativity of States.

6.Q. One of the purposes of the 2176 waiver is to learn more about the costs of delivering home and community-based services to various Medicaid populations in different parts of the country. The statute's annual State reporting requirement is intended to assure that this data is made available, in timely and accurate fashion, to the Federal government for analysis. In response to the subcommittee's June 13, 1985, letter of invitation, you supplied copies of each of the annual reports on the waiver (HCFA-371) and the annual expenditure reports (HCFA-372) submitted by the States and approved by HCFA. Although you have approved 104 waivers from 48 States, you submitted to the subcommittee only 38 approved form 371's from 25 States, and only 13 form 372's from 13 States.

a. Why is the number of approved State submissions so low?

A. The forms which we submitted to the subcommittee were not the totality of 371's and 372's which we had received from the States. We chose to submit only those with HCFA-approved content. States have cited computer problems, implementation delay, interagency coordination problems, misunderstandings, and lost files, as reasons for delay. In our own experience, States have taken from 2 to 12 months to resolve data inconsistencies pointed out by HCFA which prevent our acceptance of a cost report.

b. What steps are you taking to improve the State response rate?

A. We, of course, follow-up on all overdue reports and require the filing of acceptable cost reports as a condition of waiver renewal. We also have developed a revised HCFA Form 372 which is intended to replace the current 371 and 372 reports and have sent it to the State Medicaid Directors group for comment. We believe the use of a single form with categories more closely linked to the data submitted by States in their original applications may increase State compliance with reporting requirements.

c. When were the 371 and 372 forms first transmitted to the States for completion?

A. The 371 and 372 forms were first transmitted to the States in early 1982.

d. What analysis of the data supplied by the States on these forms are you undertaking or do you plan to undertake, both internally and externally?

A. HCFA currently uses both the HCFA 371 and 372 form to analyze each individual waiver program. Both are used to evaluate the accuracy of State cost and utilization estimates and to assess the performance of each program. This waiver specific data is also used to evaluate each waiver renewal application. HCFA has contracted with La Jolla Management Corporation to perform an aggregate evaluation of the waiver program. It uses both 371 and 372 data in its evaluation protocol. The results of the overall evaluation of the program are due in 1986.

- 7.Q. At the hearing, Ms. Matula testified that the data that the States are being required to report in connection with the waiver is not available through the Medicaid Management Information System (MMIS), and that her State of North Carolina would probably have to install a new automated data collection system or collect the required data manually.
- a. What data elements is HCFA requiring that are not available through an approved MMIS?
 - b) What is the rationale for each of these non-MMIS data elements?
- A. Since other States have not reported the level of difficulty suggested by Ms. Matula in securing data necessary for the waiver program via their MMIS systems, we cannot address these questions. MMIS systems do vary and we are not aware of the problems to which Ms. Matula has alluded. We invite Ms. Matula to submit more detailed information on this problem.
- c) Explain how these data requirements are consistent with the mandate of the Paperwork Reduction Act of 1980, 44 U.S.C. 3507(a)(1)(B), that HCFA "reduce to the extent practicable and appropriate the burden on persons who will provide information..."
- A. Both the HCFA Form 371 and 372 reporting requirements were approved by EOMB as consistent with paperwork reduction requirements. Every effort has been made to limit the data requested to essential information consistent with legislative reporting requirements.
- 8.Q. Please list the States that have, in writing, indicated their support for the provisions in the March 13 regulations.
- A. HCFA did not solicit letters of support for its final regulations. However, we have gathered extensive understanding of the States' positions, issues and needs for technical assistance at each State Medicaid Directors Conference. In general, a good rapport between the States and HCFA has been established on the waiver program; and this had led to a very productive interchange.

9.Q. On June 25, 1985, Representative Wyden introduced H.R. 2863, the Medicaid Home and Community-Based Services Act of 1985. What are your agency's views on this legislation?

- A. Until we have concrete evaluation results to support the cost-neutrality of the waiver program, we would be reluctant to make home and community-based care a State plan option. As I testified, previous research and demonstration efforts strongly suggest that cost neutrality depends on how well waiver services are targeted. Therefore, we must be concerned that the current waiver program does not actually increase Federal expenditures for long-term care.

If the current restriction that persons receiving waived services must otherwise have been institutionalized is not tightly enforced, the potential exists that a large number of new eligibles might receive a broad range of new services, adding additional program costs. Consequently, we feel we need to closely monitor and evaluate these initial State programs, some of which, in their applications and within their programs, have demonstrated the need to improve documentation of utilization and cost impacts and some of which have had difficulty in meeting other statutory assurances.

If a cap on Medicaid expenditures were to be enacted, some of our cost concerns would be lessened, but it will still be valuable to await the results of our evaluation to determine whether quality and access to care are being properly assured in community-based programs.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

August 9, 1985

The Honorable Henry A. Waxman
Chairman
Subcommittee on Health and Environment
Committee on Energy and Commerce
House of Representatives
Washington, D.C. 20515

Dear Mr. Waxman:

I am writing to correct a misinterpretation of a statement related to Pennsylvania which I made at the June 25, 1985 hearing held by your subcommittee on Medicaid home and community-based services waivers.

In response to a question specifically asking for the names of States which had provided waiver services absent a plan of care, I testified that Louisiana and Pennsylvania fit that category. This testimony was true; assessment activities conducted by my regional office staff in these States had identified problems in this aspect of program performance.

However, I would point out that Pennsylvania quickly submitted and promptly implemented a corrective action plan to resolve this deficiency noted in our assessment report. My remarks were not intended to imply that Pennsylvania's deficiencies were such that it could not submit requests for additional waiver programs. In fact, it has already done so.

I hope this resolves any misunderstanding which may have arisen concerning Pennsylvania's status under the Medicaid home and community-based services waiver program.

Sincerely yours,


Carolyn K. Davis, Ph.D.

STATE OF MICHIGAN



JAMES J. BLANCHARD, Governor

DEPARTMENT OF SOCIAL SERVICES

300 South Capitol Avenue, P.O. Box 30037, Lansing, Michigan 48909

AGNES M. MANSOUR, Ph.D., Director

June 6, 1985

Congressman Henry Waxman, Chairman
Subcommittee for Health & Environment
2415 Longworth Office Building
Washington, D.C. 20515

Dear Congressman Waxman:

We are writing to express our concerns regarding the final rules for Home and Community Based Care Waivers published in the Federal Register on March 13, 1985.

As the chairman of the committee which authored the original waiver legislation, we are requesting your assistance to pursue the intended objectives of the original waiver program. The final regulations appear to eliminate the intention of Congress to give the states "maximum flexibility in operating the waiver programs."

In fact, it is extremely frustrating for states administering community-based waivers to meet increasingly difficult and unreasonable standards. Retroactive application of certain provisions to currently approved waivers already in operation may be a real problem for many states. States are required to submit certain documentation within a 90-day period which may not be available due to unforeseen need for it. Those states who are unable to comply are threatened with termination of the waiver.

Increasingly unreasonable data requirements will effectively discourage states from participating in worthwhile waiver projects. We urge your early review of the unnecessarily harsh restrictions presented in the final rules and the administrative burden they impose. We object to the untenable position they have created for those states who have attempted to provide innovative and cost-effective alternatives to institutional care for Medicaid clients.

Sincerely,

A handwritten signature in cursive script, appearing to read "Kevin L. Seitz".

Kevin L. Seitz, Director
Medical Services Administration

cc: Richard C. Ladd



State of Louisiana
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

P. O. BOX 3776

EDWIN EDWARDS
GOVERNOR

Baton Rouge, Louisiana 70821

SANDRA L. ROBINSON, M.D., M.P.H.
SECRETARY
504/342-6711

June 18, 1985

Chairman Henry A. Waxman
Subcommittee on Health and Environment
2415 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Waxman:

I understand that a hearing has been scheduled for June 25, 1985, on the future of Home and Community Based Waivered programs. I wish to provide written testimony with regard to the undue administrative and financial burden which will be placed on this State as a result of the stringent requirements imposed by the Health Care Financing Administration (HCFA).

As you know, final regulations were published in the Federal Register on March 13, 1985. In the preamble to those regulations, the administrator of the Health Care Financing Administration states, "We do not want to limit State flexibility or initiative unnecessarily by imposing requirements that result in unnecessary and expensive administrative burdens." This final rule sustains one requirement and implements another which we believe place an unnecessary and expensive administrative burden on Louisiana:

1. Section 441.302 requires the State to provide for "an independent audit of its waiver program." This phrase has been interpreted to the State by HCFA to mean that an audit of the State with regard to its waiver must be conducted by a non-state agency. This requirement may be waived by the Secretary under certain conditions, as when the cost of such an audit will exceed the savings to the State under the waiver. However, we fail to see the need for an independent audit of the State Agency when Section 1915(e) of the Act specifically places the responsibility for monitoring waiver programs with the Secretary. This state is already subject to audit by HCFA, the General Accounting Office and the Louisiana Legislative Auditor.

We know of no other Title XIX program which requires that the States provide for such an independent audit.

2. Section 441.303(g) requires that the state provide for an "independent assessment of its waiver that evaluates the quality of care provided, access to care and cost-effectiveness." Again, this places an additional

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administrative and financial burden on the State when Section 1915(e) specifically places responsibility for monitoring waiver programs with the Secretary. While the Secretary may waive this requirement under the same conditions specified in #1 above, we fail to see the need for the States to purchase independent assessments of their waivers when HCFA already does this.

Again, we know of no other Title XIX program which requires the States to provide for such an independent assessment.


Surely it was not the intent of Congress to impose such expensive administrative burdens on the States and, indeed, such rules seem to defeat the purpose of the legislation.

We wish also to address what we strongly believe to be invalid "tests of reasonableness" used by HCFA to determine if a State's cost estimates and cost reports are reasonable. A determination of reasonableness is required before HCFA will approve a waiver request.

1. The waiver cost estimating formula was revised in the March 13, 1985 regulations to address acute care services. In the formula, Long Term Care and Waivered services are represented by factors A and C. The acute care services these beneficiaries receive are represented by Factors A' and C'. In determining whether these estimates are reasonable, HCFA makes the assumption that A = A' and C = C', which is to say that all recipients of long term care and waivered services also receive other Title XIX services. This is simply incorrect. The U.S. General Accounting Office (GAO) is currently conducting a study of this State's waiver reporting capacity. As part of that study, a sample of 95 long term care and waivered clients was drawn. Of those 95 clients, 5 had not received acute care services during the report year. While this sample was not statistical, it does clearly indicate that A does not equal A'.
2. The form 2082 is used by HCFA to determine the reasonableness of waiver cost estimates and of the waiver cost reporting forms 371 and 372. The HCFA 2082 is produced to show actual dollars spent during the Federal Fiscal Year, regardless of when the services were provided. Waiver cost estimates and the 372 are limited to payments for services provided during each year of a waiver period. In Louisiana a waiver year coincides with the calendar year. Thus, HCFA is using as a test of reasonableness comparison of reports which are:
 - a. the result of different data bases;
 - b. cover different periods of time.

Thank you for the opportunity to provide this information.

Sincerely,


Sandra L. Robinson, M.D., M.P.H.
Secretary and State Health Officer

SLR/RS/me

cc: HCFA - Dallas Regional Office
U.S. General Accounting Office - Dallas



State of Louisiana

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

P. O. BOX 3776

Baton Rouge, Louisiana 70821

EDWIN EDWARDS
GOVERNOR

SANDRA L. ROBINSON, M.D., M.P.H.
SECRETARY
504/342-6711

July 3, 1985

Chairman Henry A. Waxman
Subcommittee on Health and Environment
2415 Rayburn House Office Building
Washington, D.C. 20515

Attention: Andrew Schneider

Dear Congressman Waxman:

I wish to provide additional testimony with regard to the hearings conducted on June 25, 1985, on the future of Home and Community Based Waivered programs.

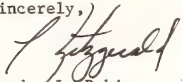
1. Subsequent to our original testimony, we learned that HCFA has determined that, in Louisiana, the Legislative Auditor may conduct the independent audits and assessments required by the new regulations. This concession does not reduce the expense to the State for such audits and assessments which are administratively costly endeavors, whoever performs them. The Secretary has stated that these requirements are intended to "enhance the Secretary's monitoring capability." In fact, these requirements force the States to assume the expense of HCFA monitoring activities as mandated by Section 1915(e) of the Act. Also, the fact remains that such requirements are not imposed for any other program under Title XIX.
2. Louisiana has a small, geographically limited Adult Day Health Care waiver request which was submitted to HCFA on March 29, 1985. A written request for additional information was received on June 28, 1985. The data requested will cause the administrative cost of developing this waiver to exceed 30% of the total estimated expenditures for vendor payment for the program. This is simply staggering when one compares it to the administrative cost of administering all of Title XIX in Louisiana, which is at this time approximately 1.4%.
3. These prohibitively expensive and time consuming requirements can only have the net effect of reducing accessibility to the elderly and disabled of programs which provide alternatives to institutionalization.

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Louisiana certainly hesitates to develop significant programming in this area while the primary funding source remains unstable and requirements for this funding become more and more stringent and burdensome.

We do not believe that the Congress intended more stringent requirements for waivers than for other Title XIX programs nor do we believe that it was intended that the States bear the financial burden of HCFA monitoring activities.

Sincerely,

for 

Sandra L. Robinson, M.D., M.P.H.
Secretary and State Health Officer

SLR/RS/me

cc: Edward R. Roybal, House Select Committee on Aging
 Senator J. B. Johnston
 Senator Russell Long
 Congressman John Breaux
 Congressman Robert Livingston
 Congressman Billy Tauzin
 Congressman Buddy Roemer
 Congressman Jerry Huckaby
 Congressman Henson Moore
 Congresswoman Cathy Long
 Congresswoman Lindy Boggs
 Janet Barbee, U.S. General Accounting Office - Dallas
 Health Care Financing Administration



STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

BILL ALLAIN
Governor

B. F. SIMMONS
Director

June 18, 1985

Chairman Henry A. Waxman
Subcommittee on Health & Environment
2415 Rayborn House Building
Washington, D.C. 20515

Re: Testimony on Medicaid Home and Community Services Waivers,
Title XIX

Dear Congressman Waxman:

The Medicaid Division in the Office of the Governor, State of Mississippi appreciates the opportunity to offer testimony on the Title XIX Home and Community Services Waiver program.

Although many states have community based care programs which have proven to be less costly and more humanitarian than long term institutional care, it is obvious that HCFA desires to severely limit the program. Their attitude is reflected in the final regulations dealing with the Home and Community Based Waivers published in the federal register March 13, 1985.

States should be allowed to design programs including whatever groups desired, i.e., aged or disabled, mentally retarded, etc. with only one waiver request for the program so long as the entire program would be cost effective. The current HCFA regulations require separate waiver requests and approvals (42 CFR 441.301).

The decision on inclusion of deinstitutionalization and/or diversion of institutionalized individuals should also be made by the state without HCFA intervention so long as the entire waiver group was cost effective. 42 CFR 441.303 (4) gives the impression that deinstitutionalization may be mandated for waiver approval.

Most importantly if it is the intent of Congress that the Home and Community Based Service Program be implemented as a long range plan to reduce the cost of nursing home institutional care for the steadily increasing number of aged or disabled individuals, this must be made clear. As evidenced by the March 13, 1985 final regulation 42 CFR 441, HCFA has implemented this as a short range means for reducing the nursing home institutional population, placing many limitations on the program waiver process.

The program can provide humane care for the long term care population at a lesser cost. Many states including Mississippi envisioned the program when initially authorized as a means of lowering the cost of long term care for the future for the increasing population in need of such care.

Again we appreciate this opportunity to offer testimony on this subject.

Sincerely,

B. F. Simmons
B. F. Simmons
Director



State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

EDDIE C. MOORE
Director

Capital Place One
222 South Warren Street
Trenton, New Jersey 08625

June 18, 1985

Chairman Henry A. Waxman
Sub-Committee on Health and
Environment
Committee on Energy and Commerce
House Annex #1
Room 512
Washington, D.C. 20515

Dear Congressman Waxman:

I have been asked to provide you with information regarding New Jersey's Community Care Waiver program and some of the difficulties we have experienced.

As I am sure you know, the Omnibus Reconciliation Act of 1981 amended Title XIX of the SSA to permit states to provide medicaid reimbursable home and community-based care services to eligible individuals who, but for such services, would require care in a SNF, ICF, or an ICF/MR. States were required to assure that average per capita expenditures for services with an approved waiver would not exceed comparable expenditures in the absence of a waiver. The state also had to assure compliance with all provisions of medicaid law not specifically waived by the Secretary. Waivers were approved for a period of 3 years with the possibility of one three year renewal.

Since most states, including New Jersey, had long believed that the medicaid program was too heavily biased in favor of institutional care, the waiver authority, though limited, was welcomed.

It was hoped that the waiver authority would be the first step toward the inclusion of home and community-based services as one of the optional services states could choose to provide for their eligible citizens under the regular medicaid program.

At present, New Jersey is in the third year of its home and community-based waiver for the mentally retarded/developmentally disabled. We were permitted to serve 600 individuals during the first year, 1300 during the 2nd year and 2000 during the 3rd year. We have received 2 highly favorable annual waiver assessments and our waiver is judged cost effective. We are presently preparing to submit a renewal application which will request increases in the number of people we are able to serve.

New Jersey Is An Equal Opportunity Employer

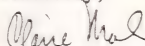
Because of the uncertainty surrounding the waiver program, our own experiences during the first 3 years and the experiences of other states, we find it impossible to say with assurance whether our renewal application will be approved and, if approved, what level of service we will be permitted to provide.

Some of our concerns are specific to New Jersey's situation others are more general.

1. Since a state may serve only those individuals who, in the absence of the waiver program, would be in a SNF, ICF or ICF/MR, the number of persons who can be served is limited by the reduction in the number of certified beds a state is able to achieve. (In New Jersey's case, a waiver was approved based on a reduction in the planned increase in certified ICF/MR beds.) This provision means that many otherwise medicaid eligible persons are not eligible for essential home and community-based programs merely because they have never been institutionalized.
2. Even if a state has an approved initial waiver and anticipates approval of its renewal application, there remains considerable fiscal uncertainty with regard to the long term future. For example, New Jersey expects to receive approximately \$10 million in FFP for home and community-based services to the mentally retarded/developmentally disabled population during year 3 of its waiver. Even if our renewal application is approved for another 3 years at the same level, we will be faced with the need to choose among replacing that money entirely with state dollars three years from now, discontinuing services, or reinstitutionalizing client in order to maintain FFP.
3. Under the terms of the waiver (as indeed in all medicaid long term care programs) funding is available for "habilitation" services but not for educational or vocational services. Unfortunately, there may be considerable overlap in the clinical activities undertaken under the labels "habilitation", "education", or "vocation services". In spite of repeated requests, the Health Care Financing Administration (HCFA) has never provided states with clear definitions of the above terms. States are left "out on a limb" with regard to the eligibility of the services they legitimately term habilitation.
4. Criteria by which waiver applications, renewals and amendments are reviewed and approved are often unclear and appear arbitrary. States are often pressured by phone to alter their submissions at the last moment or face rejection and the consequent delay of restarting a new 90-day cycle. For example, New Jersey recently submitted a 3-point proposed waiver amendment. On the 89th day we were notified by telephone that our proposals were unacceptable and would be rejected. We agreed to drop one of the points but informed the Health Care Financing Administration's official that his interpretation of the implications of the other two points was factually incorrect. We provided evidence of same by facsimile machine, but were told our amendment was rejected without consideration of the supporting material. Such high-handed behavior is commonly reported by other states and is encouraged by the lack of clear criteria.

I hope this information is useful to you. Please feel free to contact me at 609-292-7354 if I can be of service.

Sincerely,



Claire Mahon
Assistant Director



STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND WELFARE

DIVISION OF WELFARE

Hazen Drive

Sylvio L. Dupuis, O.D., Commissioner

Richard A. Chevrefils, Director

Concord, NH 03301

603-271-4326

June 19, 1985

Honorable Henry A. Waxman
 Chairman
 Subcommittee on Health and
 the Environment
 2415 Rayburn House Office Building
 Washington, D. C. 20515

Dear Rep. Waxman:

New Hampshire Medicaid applied for a waiver under the Omnibus Reconciliation Act, 1981, to provide Medicaid services beyond the scope of its existing plan to the elderly and chronically ill. Application was complete 12/23/83, approval received 3/22/84 and implementation began 7/1/84.

In developing and implementing this waiver the state experienced problems to be expected in beginning a new program. Most of these difficulties were around public awareness, training needs and complex eligibility criteria.

Two areas however continue to emerge as barriers to implementation and participation in the home care services provided through the waiver.

Waivers are exceptions to the rule, and these 2176 waivers are exceptions to many rules. A great deal of confusion has resulted from borrowing eligibility criteria from Medicaid and Economic Services policy that this group of people require. For example, initial application of eligibility criteria is based on the standard of need for nursing home recipients. Income and resources are treated as a family of one and eligibility established. As a diversion from nursing home care, the medical evaluation establishes need for Intermediate Level of Care. Confusion results in two areas after this process is complete. First, eligibility for other assistance, including money payment when the recipient or spouse's income falls below the state's standard of need must be determined and still another set of regulations for money payment, as a couple, apply. Secondly, problems arise in the post eligibility treatment of the recipient's income for cost share purposes. This requirement sets a barrier to participation in the waiver, not because the recipient should not or is unwilling to participate in the cost of care. The problem in the regulation is in tying that protected income level to the state's standard of need. It then relegates frail, sick, elderly who were not part of a poverty group to a poverty level increasing the numbers of people at that level, or creating a new group of poor.

Of further consideration is the fiscal impact of adjusting the standard of need or utilizing a different financial standard to compensate for the above problem. It would then mean we must raise the standard for other potential Medicaid recipients increasing the state and federal expense for Medicaid reimbursement.


Our final difficulty with the waiver process is the untimely delay in final regulations. The New Hampshire waiver was written and approved according to the interim regulations. However, our assessments and our renewal will be against a different set of rules. Given the complex nature of eligibility and the frail condition of the recipients of this program, it is inappropriate and administratively unsound to grant waivers, change the rules and then hold states and recipients accountable. Further, the renewal process is therefore compromised and jeopardized despite an otherwise successful endeavor.

It would appear that programs designed as exceptions to the rule are unnecessarily complicated and are not provided the opportunity to evolve as viable and cost effective practices in their own right. Exceptions breed confusion and complications.

The experience of New Hampshire in implementing this waiver illustrates an inadequate response to a growing need. The elderly as a group is growing and our response to the needs of this group might well be more effective if programs are funded and designed based on their needs rather than "borrowing" from other programs and designing services on "exceptions to the rule."

Therefore, the success of current waivers in providing viable alternatives to the elderly and avoiding institutionalization should be supported by a Congressional commitment to this population. This commitment should not be couched in the regulations as a sub-category to existing regulation, but, legitimized through federal mandate (another Title to the Social Security Act) made available for state option tailored to state needs.

Very truly yours,



Philip P. Soule
Administrator
Office of Medical Services
(603) 271-4353

cc-Janice Coffey
Eileen Doole



New Hampshire State Council on Aging

WILLIAM E. SANBORN

Chairman

ANNA M. PLUHAR

Director

In Reply Refer To:

June 21, 1985

The Honorable Henry A. Waxman
Chairman
Sub-Committee on Health and the Environment
2415 Rayburn House Office Building
Washington, D.C. 20515

Dear Rep. Waxman:

This letter is in response to your request for information on the implementation of the Medicaid community care waiver or the Home and Community Based Care (HCBC) program. There are some fundamental problems with the program that may prevent it from realizing its intended goal of making home care a viable alternative to nursing home care.

There are three fundamental problems that have come to light in New Hampshire.

- (1) Potential HCBC clients are discouraged from using the program by the low living allowance to pay for at-home expenses (\$328/month/individual). The standard of need living allowance should adequately reflect the expense of living at home.
- (2) There is a problem with the requirement that at-home cost be the same or less than the average cost of nursing home care over a six month period. This cost limit does not accurately reflect the cost of actual services to the HCBC client, who is eligible to receive Title XX and Administration on Aging funded services for which the client does not pay. Therefore, the cost of these services is not figured into the average daily cost of care for the HCBC client and the HCBC figure does not accurately reflect the cost of maintaining a HCBC client at home.
- (3) Another major problem with the HCBC program lies with the physical eligibility requirements which require that a HCBC applicant must meet Intermediate Care Facility (ICF) standards for eligibility. If a person needs 24-hour nursing care, as ICF eligibility standards require, then practically, how can that individual remain at home? HCBC can not pay for 24-hour nursing because the cost would be prohibitive. If the person does not need 24-hour nursing care he/she should not be eligible for ICF care. To carry out a successful HCBC program, the eligibility standards must be re-assessed to allow those people who are capable of remaining home to do so, whether or not they meet ICF eligibility criteria.

These are flaws in the HCBC program which have made it very difficult for the program to meet its stated goal of providing in-home care.

Thank you for giving us the opportunity to participate in the hearing process. Your continuing concern for elders who are in need is appreciated.

Sincerely,

Anna M. Pluhar
Anna M. Pluhar
Director



RICHARD D. LAMM
GOVERNOR

State of Colorado

DEPARTMENT OF SOCIAL SERVICES

1575 SHERMAN STREET
DENVER, COLORADO 80203

GEORGE S. GOLDSTEIN, Ph.D.
Executive Director

June 24, 1985

The Honorable Henry A. Waxman
Subcommittee on Health and
the Environment
2415 Rayburn House Office Building
Washington, D.C. 20515

Attention: Andy Schneider

Dear Representative Waxman:

The following is provided as written testimony for the Subcommittee on Health and the Environment's hearings on the Home and Community Based Services (Medicaid 2176 Waiver "HCBS") program. This testimony is divided into three sections: (1) The present situation in Colorado, including recent renewal of the waiver under a cap; (2) Issues in the administrative relationship between the State and HCFA; and (3) Colorado's perspective and recommendations on development of the Long Term Care (LTC) system. This testimony is focused on the Elderly, Blind, and Disabled (EBD) waiver/program.

1. Colorado's HCBS (EBD) program is one of the most successful in the Nation, in terms of state-wideness, comprehensive services offered, growth and effective system function. Although we are completing our 3rd year of the original waiver period with nearly 3,000 clients and a monthly growth in clientele of close to 100 clients, HCFA would not renew our waiver request unless we agreed to a "cap" of 3,100, 3,300, and 3,500 clients for FY's 86 through 88. In addition, we are capped at annual cost per client increases of 10%, 4% and 4%. These costs have been rising at 18% in the past year and would continue to do so, because of the program's low initial daily costs (approximately 1/3 the Nursing Home rate) and our increasing concentration on heavier care clients.

The net effect of this cap, therefore, is a "freeze" on an effective program of alternatives to Nursing Home Care. This amounts to a reinstitution of the Medicaid institutional bias in LTC, which the waiver/HCBS programs were designed to counteract. Unless the cap is lifted, we anticipate significant dislocations for LTC clients and shifts to higher cost care options.

2. We believe that both states and HCFA share a concern about the effective administration of the program to provide cost effective care alternatives to individuals at risk of institutionalization. Reversing the institutional bias of Medicaid LTC services, while containing costs and serving eligible clients with quality and appropriate services, is a shared goal. It requires a cooperative approach, with clear communication and mutual problem solving. Our experience in this regard has been less than satisfactory. The administrative treatment of states by HCFA, throughout the waiver renewal process and through the excessively restrictive requirements of the new "Final" HCBS regulations, can be described as arbitrary and inconsistent. Arbitrary, because regulations require states to supply HCFA with "reasonable and data based cost effectiveness calculations". Yet, when Colorado has supplied such data and estimates, HCFA has refused to accept them or to articulate reasonable alternate methods or standards of proof of cost effectiveness. Inconsistent, because the data and program narrative/ design requirements are constantly changing.

In the renewal process, for example, our staff has been subjected to telephone "requests" from HCFA which:

- ° Required, on a one-and-a-half week turnaround, 22 items of response, 18 pages (7 pages of new data) of response, and detailed explanation of methodology;
- ° Subsequently required, on four-day and two-day turnarounds, new explanations, new data, and new methodologies;
- ° Threatened disapproval of the renewal if the State did not supply the voluminous new material on the short timeframes, and accede to HCFA's new (and constantly changing, depending upon who was on the phone for HCFA) methodologies or definitions or "suggested" formula values. Colorado's requests for explanations of the basis for these changes and requirements for new information were met by the suggestion that Colorado should consider withdrawing the waiver renewal and submitting, instead, a new application under the new formulas and requirements in the "Final" regulation.

The "Final" regulations, themselves, and the procedure under which they were promulgated and applied to existing programs, are, themselves, objectionable to Colorado. I would refer you to Oregon's and APWA's testimony in this regard. Colorado agrees that the substantial and overly restrictive changes to the regulations are unwarranted, are inconsistent with Congressional intent, and are improperly promulgated in such radically changed form without a new public comment period.

HCFA staff have repeatedly told us that they are under great pressure from the Executive Office of Management and Budget (OMB) to cap and limit these waivers. They have advised the State to "save" the waiver programs by agreeing to the "freezes" and caps. We have done so very reluctantly, and with the assurance from HCFA that "amendments" to the waiver, which adjust the caps to reflect appropriate program utilization are possible. We believe that a clear expression of Congressional intent in regard to the growth and viability, under reasonable administration, of the waiver/programs, will be essential to the success of this effort to provide appropriate and cost-effective services to those in need of Long Term Care.

I would like to call your attention to the Draft Resolutions of the October, 1984 HCBS Second National Conference, which I have attached. These recommendations to HCFA on improvement of the administration of HCBS were not only timely in 1984, but remain critical issues now since HCFA has continued to abuse its administrative discretion, and continues to fail in working cooperatively with the states to effectively carry out the implementation of this important LTC initiative. For instance, new reporting requirements (new data bases/information on cost effectiveness) are currently in promulgation. HCFA has permitted only one state to see or comment on these, despite their impact on complex information systems and HCFA's history of requiring reporting systems which do not do the job intended. Combined with retroactive application of these requirements, and threats of program termination for non-compliance, the need for an open and cooperative process is underlined.

3. In a more positive vein, Colorado offers the following perspectives on Long Term Care system development, for your committee's consideration:

- ° Demographic (60+, 75+ population growth) and functional need (higher, longer-term chronic illness and debilities) trends point to the increasing importance of humane, cost-effective, integrated and accessible systems of Long Term Care in the coming years. The Continuum of Care approach, wherein all persons in need of supports can be accessed to services efficiently and effectively, is suggested as the model of choice for service delivery. While not suggesting that public funding should foot the entire bill for LTC, it is seen as crucial that public fund supports remain adequate and that they be well integrated with other supports in a Continuum.
- ° For the immediate future, the HCBS program must be retained and strengthened as the best method of eliminating the institutional bias of Medicaid. Taxpayers, clients and families must not again be faced with the unacceptable choices of institutional care or no care assistance at all. Home and Community Based care options and services (as well as providers and administering systems) have proved themselves as viable, humane, acceptable to clients, and cost-effective. These systems must be fostered and integrated with other care/benefit systems up and down the Continuum of Care, in the coming years. Colorado

is proud of its role as a leader in this effort, and invites you to explore with us the development of the LTC system.

- ° This Department supports such efforts as Senator Bradley's bill to make HCBS an optional service, and thereby improve program stability and system development. In the short term, this would appear to present the best opportunity to contain Long Term Care costs while providing essential services. It would seem prudent in present circumstances to clearly incorporate a statement of Congressional intent in any legislation, including the intent that these programs shall be open to those entitled to services, without caps or unreasonable restrictions imposed at the Federal administrative levels.
- ° Although states have an equal concern for and involvement in the funding of (and have the primary system development and service delivery roles for) LTC systems with the Federal government, the withdrawal of Federal supports and responsibility for LTC would not be a reasonable alternative. The specters of interstate migration of persons seeking essential care and the inability of less economically healthy States to support LTC systems, and the clear potential of Federal-State-Interstate cooperation in the advancement of these systems, all argue for a continued Federal/State partnership.
- ° Such potential major changes in the methods of delivering and funding LTC are Federal/State payments for LTC insurance (the creation of a risk pool through such mechanisms as SHMO's), and the clearer definition of LTC as a system of social supports with a medical service component (rather than the present, opposite approach) should be explored. Potentially greater flexibility for States in system design which exist in a separate Social Security Act Title or block grant approach must be weighed against the possibility of block grants being accompanied by drastic cutbacks of Federal funding support.

I appreciate this opportunity to present testimony to you on these vital issues, and commend your activities in behalf of our LTC clients. Please be assured that Colorado will continue to creatively and vigorously promote humane and cost-effective LTC systems. Should you desire further information, please contact my office or the Aging and Adult Services Division (Tom Kowal/Bill Hanna), at (303) 866-3142.

Sincerely,



George S. Goldstein, Ph.D.
Executive Director

Enclosure

DRAFT

RESOLUTION

The participants in the Second National Conference on Home and Community Based Waivers recommend to HCFA that the following administrative actions be taken:

1. If substantial changes are made by HCFA in the interim final regulations now in effect with respect to home and community based care waivers, those rules should be published for public comment with a reasonable time frame for responses from the states. Any standards to be applied to the evaluation or consideration of continuance of waivers should be provided well in advance of required state action and should be in written, not oral, form.
2. HCFA inquiries of states (such as new data requests, clarifications, explanations, supporting documentation) should be in written form and provide adequate timeframes for response from states, without penalty assessment such as loss of waiver or FFP.
3. Data requirements and formats should be developed with review and comment by the states, and not be applied retroactively to existing waivers with sanctions or waiver or loss of FFP. HCFA should work with states to develop good data and cost effectiveness analyses. For instance, until problems with the 371/372 reports are cleared up, these should not be used as reasons for waiver sanctions.
4. HCFA should stipulate that projected client and cost figures contained in waiver formulas and other calculations are subject to reasonable on-going negotiation upon the development of more complete or current data by the states or HCFA; waiver sanctions should not be imposed on the basis of arguable statistical interpretations.
5. HCFA should apply whatever final regulations are implemented in a consistent way across regions, and over time. Lack of clear direction and contradictory interpretations create enormous administrative difficulties and uncertainties at the state level, as well as making for a less well managed demonstration project nationally.
6. HCFA needs to re-examine the formulas used for cost comparison, particularly with respect to its applicability to care for non elderly physically handicapped adults and medically fragile children for whom the level of care and type of services provided through ICF, SNF, or ICF/MR are not appropriate and for whom comparisons with the cost of care in these institutions is therefore also not appropriate.

7. HCFA should acknowledge the role of the waivers beyond cost containment, and should explicitly be evaluating the program's overall performance and that of individual states. The waiver program is part of a continuum of long term care services needed to assure that elderly, handicapped, developmentally disabled, medically fragile and others in need of long term care receive adequate care and supports. The waiver should not be regarded only a mechanism for saving money by diverting individuals from nursing homes and large institutions, but rather must be evaluated in terms of its overall cost effectiveness relative to institutional care. The quality of the care provided to clients and the benefits they receive by remaining at home or in a community setting rather than entering an institution should be included in any evaluation of the waiver program and in making a determination regarding its continuation as a program.

8. HCFA needs to re-examination its cost sharing requirements that currently impose unfair hardships on some participants (e.g. the elderly whose income is above SSI but who have various extraordinary expenses such as home repairs that cannot be deducted), while allowing others (e.g. the parents of a handicapped child) not to pay anything towards the care of the participant.

9. HCFA should encourage and support creative demonstration projects along with lines of the Social Health Maintenance Organization. Additional demonstrations of the SHMO and of similar models for other long term care populations should be initiated. Of particular interest is the encouragement of blending Medicaid, Medicare, and private health insurance and the ability to finance a wide range of service delivery approaches.

10. HCFA should provide more training and technical assistance to states with respect to applying for and implementing waivers, along with creating more opportunities for states to share their experiences with each other.



State of Georgia
Department of Medical Assistance
 Floyd Veterans Memorial Bldg. - West Tower
 2 Martin Luther King, Jr. Drive, S.E.
 Atlanta, Georgia 30334

Aaron J. Johnson
 Commissioner

June 24, 1985

Honorable Henry A. Waxman
 Chairman, Health and Environment Sub-Committee
 House Committee on Energy and Commerce
 2415 Rayburn House Office Building
 Washington, D.C. 20515

Dear Congressman Waxman:

I am writing to you regarding the final regulations governing Section 2176 Home and Community-Based service waivers which HCFA published in the March 13 edition of the Federal Register. We find several of the provisions to be contrary to both state objectives and the overall purpose of the Title XIX Medical Assistance program.

The most significant problem in the regulations is the requirement found in 42 CFR 441.302 (2) that the Medicaid "agency's actual total expenditures for home and community-based services under the waiver and its claim for Federal Financial Participation (FFP) in expenditures for the services will not exceed the approved estimates for these services." The formula for estimates is the product of the estimated number of individuals who would receive home and community-based services under the waiver times the estimated annual Medicaid expenditure per individual. By not allowing FFP in expenditures for more persons than originally estimated in the waiver request, HCFA seems to be ignoring the broader premise of the waiver legislation that aggregate expenditures under the waiver not exceed those which would have occurred in the absence of the waiver. The regulatory interpretation does not allow for an increase in a state's elderly population, nor does it recognize the inevitable increase in nursing home beds if the state did not have home and community-based services to serve its aging population. The regulation has the effect of encouraging nursing home care at higher cost to both the federal and state government.

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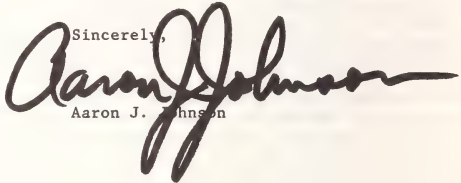
A second concern which we have with the final regulations lies in HCFA's assumptions regarding the ratio of community placements to nursing home recipient reductions. The new regulations are based upon the premise that only one individual has to be served by home and community-based services in order to reduce the nursing home caseload by one patient. Experience in Georgia and other states has shown that the actual rate of diversion and relocation from nursing facilities has to be higher than the one-to-one ratio in order to control nursing home utilization because of the ever-present demand for empty beds.

A costly ramification of this one-to-one ratio assumption is the apparent requirement that a nursing home bed must be kept available for every individual being served under the waiver in the community. This provision seems to run contrary to Congressional intent to contain long-term care costs through the provision of home and community-based services. It is not compatible with the cost-effective control of institutional long-term care which should be achieved by the provision of community-based services in emptying and closing-down nursing home beds.

I was glad to hear that you intend to hold hearings this summer on the experience of states with home and community-based services under the present law and new regulations. It is my hope that the subsequent deliberations by the Health and Environment Sub-Committee will lead to recision of the more objectionable provisions of the new regulations and elimination of the waiver requirement for home and community-based services. We would prefer that home and community-based service be made an optional State plan service.

Georgia and all states appreciate your concern and involvement in this important issue. If I can provide you with information regarding Georgia's Medicaid program, please do not hesitate to contact me at (404)656-4479.

Sincerely,

A handwritten signature in dark ink, appearing to read "Aaron J. Johnson". The signature is fluid and cursive, with a long horizontal stroke at the end.

Aaron J. Johnson

AJJ:clm

GEORGIA DEPARTMENT OF HUMAN RESOURCES
OFFICE OF AGING

COMMENTS ON THE HCFA WAIVER

The Office of Aging has had an opportunity to review the rules and regulations for implementing the Home and Community Based Services Medicaid Program which were effective April 12, 1984. We are pleased to have an opportunity to provide a written statement of the potential impact of these rules and regulations.

1. The Office of Aging supports strongly safeguards to protect the health and welfare of beneficiaries by adherence to the key amendments. However, imposing this restriction on all waived services such as home delivered services, which are provided in a clients home is unrealistic.
2. The requirement of an independent audit and an independent assessment appears unrealistic due to the costs involved. It is also significant to point out that HCFA has funded research projects to assess the impact of the Home and Community-Based Waiver program. Any additional required assessment of the program would be duplicative and the time frame for completion is unrealistic.
3. The requirement that states must provide HCFA with an assurance that aggregate Medicaid expenditures for all services provided to individuals under the waiver do not exceed the aggregate Medicaid expenditures that would be incurred for these individuals in the institutional setting in the absence of the waiver is unfair. When a client is institutionalized much of the medical care is included in the nursing home daily rate. Also clients residing in nursing homes may not have access to hospital care facilities due to the care received in the nursing home. This is not the case for those clients remaining in the community receiving waived services. Their care is not based on 24 hour care with easy access to nursing services. This requirement appears unjustified as well as unfair.
4. The equation that HCFA is imposing for states to determine the cost effectiveness of the waiver program overlooks the emotional growth in persons over 65, 75 and 85. This is not even taken into consideration. Their formula simply assures us that the average per capita expenditures for individuals under the waiver do not exceed the average per capita expenditure, that would have been made under the state plan had the waiver not been granted. The factors in the equations to allow comparison of total Medicaid costs with and without the waiver needs to be re-evaluated in light of the comments made in response #3. The formula also restricts the number to be served under the waiver based on nursing home statistics rather than actual need for community based services. This appears to be incongruent.

It is essential to point out that the waived services program should continue and states should be allowed as much flexibility in administering this program.

The Office of Aging appreciates the opportunity to offer comments on this crucial program which has provided needed services to numerous Medicaid eligible individuals.



THE SECRETARY FOR HUMAN RESOURCES
COMMONWEALTH OF KENTUCKY
FRANKFORT 40601

June 24, 1985

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Attention Mr. Andy Schneider
2415 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Waxman:

This letter is to make known to you Kentucky's interest in and support of the home- and community-based services (HCBS) waiver option.

We currently have two HCBS waiver projects. One project provides alternatives to institutional care for the aged and disabled, while the other project is directed to the special needs of mentally retarded and developmentally disabled individuals.

Through these projects we are able to serve clients with a wide range of care needs in the community, instead of in an institutional setting. Some may require one or a few of the waiver services, while others require the full range of services offered. We urge the continued involvement of families and friends and our records indicate that this is occurring.


Further, the cost data indicates that waiver services are cost effective. The availability of home- and community-based services will reduce the need for and hopefully prevent the construction of more long term care facility beds. Waiver services provide a less costly alternative to institutional care, while at the same time allowing the recipient to exercise some control over the setting in which he will receive services.

We are concerned that the Health Care Financing Administration is interpreting legislation pertaining to waivers in an overly stringent manner.

Also, we do feel that the use of data comparing all Medicaid expenditures for waiver recipients to those for institutionalized recipients gives a better analysis of cost effectiveness than the comparison made under the original formula. However, the calculation method could be rendered more accurate by using patient years rather than unduplicated patient counts.

Again, Kentucky strongly supports the home- and community-based services option. We solicit your support and that of the Subcommittee on Health and the Environment.

Sincerely,


E. Austin, Jr.
Secretary

Chairman, Subcommittee on Health and the Environment
Congressman Henry A. Waxman
June 25, 1985

On behalf on the Governor's Commission on Senior Services in Oregon, I want to state our beliefs and position regarding the Home and Community-Based Waivers which have been a part of Oregon's system for the last three and a half years.

We believe that the waiver forms the very cornerstone of senior services made possible by the Senior Services Division.

The impact of the waiver has been enormous, not only in terms of wide use of the scarce human resource dollar but, even more importantly, in terms of value to human lives.

Thousands of Oregon seniors have had their lives enriched -- enhanced -- and extended. As the result of the waivers, they are able to live their lives independently as possible, remaining in their own homes as long as possible or in a smaller residential setting other than nursing homes. This is a choice every older American should have.

Without the waiver, Oregon's elderly lose the choice they now have to live in the most independent setting. Nursing homes, at a much higher cost, would be the option offered. In terms of human suffering, this is an unacceptable option.

We would like to be assured that the type of service offered by the waiver will be continued, and in a form that permits states flexibility to meet their individual needs.

With the proven experience of a successful program, Oregon should be permitted to continue, serving more persons, in a better way, and with cost savings.



COMMISSION
FOR HUMAN SERVICE

State of Oklahoma
Department of Human Services

Sequoyah Memorial Office Building
P.O. Box 25352
Oklahoma City, Oklahoma 73125



ROBERT FULTON
Director of Human Services

June 27, 1985

Honorable Henry A. Waxman
United States Congressman
Subcommittee on Health and Environment
2418 Rayburn House Office Building
Washington D. C. 20515

Dear Congressman Waxman:

We are writing regarding our concerns about the interpretation of the Medicaid Section 2176 home and community-based waivers as promulgated in the March 13, 1985 Federal Register by the Health Care Finance Administration. Additionally, we are concerned about HCFA's approval process for applications. Our concerns pertain to the following issues:

- Administrative Flexibility
- Impact of Cost Effectiveness Formula
- Sanctions for Exceeding Formula Estimates
- Documentation Requirements

Administrative Flexibility

It is clear from the statute that Congress intended to allow states flexibility in the administration and design of the waiver program. This is indicated in broad language on 1) allowable services and 2) fiscal limitations which only require an assurance that costs for medical assistance to waived individuals not exceed costs for persons currently served under the state plan.

This flexibility has been eroded through HCFA action during the application review process. The Oklahoma Medicaid agency witnessed this erosion during the waiver application process for provision of inhome and community-based services for mentally retarded individuals. Last minute reviews and deadlines created barriers throughout the review process giving the perception that expediting approval of such programs was not the intent at the federal level.

Impact of Cost Effectiveness Formula

We recognize the need for controlling the growth of long term care costs. However, we believe that massive restrictions to long term care alternatives which are found in a small component of the long term care Medicaid budget is not the way

to address this issue. The cost effectiveness formula in the March 13th regulations, which requires that total costs for community services and acute care services for waived clients be less than total costs for institutional and acute care services for current recipients, seems to diverge from Congressional intent that Medicaid long term care costs should be controlled in the aggregate. The formula limits states' flexibility to design services which are most appropriate for recipients because waived service costs are so closely scrutinized. It appears that the formula creates a "tail wagging the dog" situation wherein any overall changes in Title XIX services or eligibility have to be measured against their impact on the waived program.

Sanctions for Exceeding Cost Estimates

The threat of termination of the waiver if a state exceeds estimates of total waived costs inhibits many states from applying for the waiver. Additionally, it puts states at risk when programs have been implemented but can be penalized at any time through termination based on estimated costs. It appears that a more useful review would be to assess the growth level for all Title XIX services rather than direct such extensive reviews to a relatively small percent of total state Medicaid budgets.

Documentation Requirements

The extensive array of documentation required in the regulations in the areas of 1) distinguishing deinstitutionalized individuals from deflected/diverted individuals; 2) evaluation and screening procedures; 3) referral sources; 4) nursing home and community service utilization patterns; and 5) recipient counts again impedes state flexibility in designing and monitoring such programs.

It seems that the focus of federal concern should be overall fiscal and programmatic reviews of the Medicaid program, delegating to states the responsibility to design and monitor program components.

It is for these reasons that we suggest the Subcommittee recommend the following options:

Option 1

In the short term, as an intermediate step to option 2, we suggest block granting long term care services within Title XIX as a mandatory service. Long term care should include services to all residents at risk for institutionalization, i.e. elderly, adult physically disabled, mentally retarded and developmentally disabled individuals. Further, the block grant would include a continuum of services arrayed with programs currently allowed under the inhome and community-based waiver

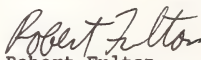
through institutional offerings. The block grant should be funded, at a minimum, at the current level of programs which would be incorporated in this approach. Funding adjustments in future years should be tied to an inflation index which uses a health care marketbasket. This form of block grant approach would preserve programs and their funding bases. Further, it would allow states flexibility in program design. States could determine cost effectiveness of all long term care services by the manner in which they commit and allocate resources.

Option 2

In the long term, we suggest creating a separate title under the Social Security Act pertaining to continuing care. This recommendation assumes that recipients under a continuing care system have chronic medical problems which necessitate services substantively different than the acute care focus of Title XIX services. The act should provide for a series of options ranging from community/inhome care through institutional services. Additional services would address gaps in the continuum of care model which, in all probability, could not be added under a block grant approach. Funding would need to be increased under this more comprehensive model with periodic adjustments made for inflation. Creating a separate title would ensure that resource allocation is proportionate and clearly targeted to a group of recipients the new act intends to serve.

We appreciate your time and attention to this program which is of benefit to so many constituents in need of supportive arrangements to remain in their home and community.

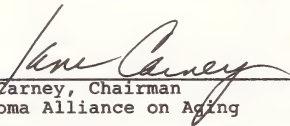
Sincerely,



Robert Fulton
Director of Human Services



Jean Cooper, Ed.D., Assistant Director
For Developmental Disabilities



Jane Carney, Chairman
Oklahoma Alliance on Aging



Beulah Gwin, President
Oklahoma State Senior Advocates

July 1, 1985

STATEMENT OF TESTIMONY
OVERSIGHT HEARING ON MEDICAID HOME AND
STATEMENT OF TESTIMONY

THE HONORABLE HENRY A. WAXMAN, CHAIRMAN

The State of South Dakota encourages you and your committee to consider legislation to authorize home and community care as an optional state plan service under Medicaid.

In this brief statement it is impossible to describe the many problems our State has had, and is having, trying to implement a very worthwhile program, i.e. Home and Community-Based Services. The Health Care Financing Administration is placing limits on both aggregate expenditures, and on the total number of people who may be served under our waiver. After a very confusing period of negotiation, we finally received approval of a threeyear continuation of our HCBS waiver. However, HCFA refused to approve increases in community care rates. This arbitrary decision was made in spite of the following facts: 1) our HCBS rates were already among the lowest in the nation; 2) we were able to demonstrate that the cost for community care has been, and will continue to be, substantially less than costs for institutional care; and 3) such increases had already been approved by our State legislature.

We truly feel that the HCBS program is one of the best alternatives provided by Congress for the appropriate care and treatment of developmentally disabled people. This alternative can only remain a positive program if States can maintain the flexibility to use it in accordance with each State's needs, and as long as they can demonstrate its cost effectiveness and efficiency.

Thank you for your consideration of this testimony.

Thomas E. Scheinost, F.A.A.M.D.
Program Administrator
South Dakota Office of
Developmental Disabilities

July 1, 1985

Dear Representative Waxman:

I would like to offer support for testimony provided by the Consortium for Citizens with Developmental Disabilities on June 25, 1985, before the Subcommittee on Health and the Environment concerning the Medicaid Home and Community Care Waiver Authority. In particular, I would highlight the following:

1. The current method of restricting eligibility for waiver services has served as a disincentive for Colorado to include within its waiver high volume but low cost alternatives to prevent out-of-home placements such as family resource services. Our experience has been that even very modest services (i.e. less than 10% of the per capita institutional cost) to families can delay indefinitely the time at which a costly placement may be considered.
2. The prohibition against prevocational and vocational training and educational activities is totally contradictory to the programmatic needs of persons with developmental disabilities targeted for deinstitutionalization and, therefore, can and has served as a disincentive to the use of waiver services to promote such placement.
3. The loose, if not subjective, operational criteria for determining the boundaries of an acceptable waiver proposal promote a bureaucratic and wasteful process for the states and HCFA. The unpredictable nature of this process serves as a disincentive to pursue cost-effective alternatives to institutional services.

I strongly support the waiver as a means to decrease use of institutional services.

Jeffrey A. Sandler, Director
Division for Developmental Disabilities
Denver, Colorado
JAS:rmh



LARRY L. LATHAM
ASSOCIATE COMMISSIONER
FOR MENTAL RETARDATION

STATE OF ALABAMA
**DEPARTMENT OF MENTAL HEALTH
AND MENTAL RETARDATION**

200 INTERSTATE PARK DRIVE
P.O. BOX 3710
MONTGOMERY, ALABAMA 36193-5001



GEORGE C. WALLACE
GOVERNOR

July 3, 1985

The Honorable Henry A. Waxman, Chairman
Subcommittee on Health and the Environment
House Committee on Energy and Commerce
Room 2424, Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Waxman:

The Alabama Department of Mental Health and Mental Retardation as the provider of services under a 2176 Home and Community-based Waiver for the Mentally Retarded and Developmentally Disabled supports the "State of Testimony of the Medicaid Task Force of the Consortium for Citizens with Developmental Disabilities," and recommendations (contained in Section III, A, 1 through 3) for Subcommittee action. Alabama experienced most of the difficulties outlined in the Statement of Testimony during its initial efforts to secure a waiver for the mentally retarded and developmentally disabled and is, thus, sympathetic to the needs for clarification. We are particularly concerned regarding the overall divergence of waiver policies and interpretation of Congressional authority, since Alabama's waiver renewal request has recently been submitted to the Health Care Financing Administration. The waiver process as currently administratively defined intends to undermine the very flexibility so key to the cost-effective utilization of Title XIX designated state and federal dollars to achieve deinstitutionalization.

We urge action by the Subcommittee to resolve this issue in the most expedient manner possible. By copy of this communication and the Statement of Testimony to the Alabama Congressional Delegation, we are calling their attention to current concerns of almost every State in the union in regard to this federal program.

Sincerely,

Larry L. Latham, Ph.D.
Associate Commissioner for
Mental Retardation

LLL:ej

cc: Alabama Congressional Delegation
NASMRPD



STATE OF ILLINOIS
DEPARTMENT ON AGING
421 EAST CAPITOL AVENUE
SPRINGFIELD 62701

JANET S. OTWELL
DIRECTOR

July 3, 1985

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health and the
Environment
2415 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Waxman:

The State of Illinois Department on Aging would like to submit the attached testimony on Home and Community-Based waivers for your consideration. This testimony is being provided at the encouragement of Richard C. Ladd, Administrator with the Department of Human Resources for the State of Oregon.

We appreciate the opportunity to address these very important issues. Thank you for your continued interest and support in the provision of community-based services for frail older persons.

Sincerely,

A handwritten signature in cursive script that reads "Janet S. Otwell".

Janet S. Otwell
Director

JSO:glw

Attachment

HOME AND COMMUNITY-BASED WAIVER TESTIMONY

Background

The Illinois Department on Aging has administered a statewide home and community-based service program for frail older persons since 1979. In July, 1982, as a result of a Federal court order, the program became an entitlement program offered to all eligible persons at risk of inappropriate institutionalization. Simultaneously, we began to develop a Title XIX waiver request and received approval in July, 1983. The Illinois waiver covers non-institutionalized persons who are eligible for regular Medicaid services in the community.

Illinois' Medicaid waiver is one of the largest in the nation, serving 8,154 clients in FY 1984 and approximately 9,000 in FY 1985. In spite of its size, waiver program expenditures represent only thirty-percent (30%) of total expenditures. The remainder of the caseload, funded by the State, is comprised of persons who could convert to Medicaid within one year of entering a long term care institution.

Illinois' waiver program has proven to be very successful. Data show a twenty-four percent (24%) reduction in nursing home utilization since implementation of the waiver. The data also verify that the nursing home and home care caseloads combined are no greater than the nursing home population would have been if home care was not available. Because no more clients are being served and home care costs less than nursing home care, the state has achieved a substantial savings. We estimate a savings of approximately \$71 million in FY 1985, \$46.1 million of which represents savings to the Federal Medicaid program.

General Constraints of the New Regulations

In March, 1985, new Federal regulations were implemented which severely affect the home and community-based waiver programs. Some of the direct effects of the regulations are:

- . The punitive effect upon pre-existing home and community-based programs.
- . The lack of recognition of the "woodwork" effect.
- . The inappropriate emphasis upon deinstitutionalization.
- . The impact upon the waiver development and extension process.

The regulations fail to acknowledge that some states have pre-existing home and community-based programs. This lack of recognition creates a hardship for large state programs, such as ours, which have the foresight to recognize the need for the services, and to implement a cost-effective program prior to receipt of the waiver. Illinois' claim, which includes a pre-waiver caseload, has been questioned, in spite of the fact these pre-waiver clients meet the same criteria and continue to be at risk of unnecessary institutionalization.

The regulations require that for each person served by the waiver program, one (1) person must have been at imminent risk of institutional placement. This assumption ignores the reality of a "woodwork" effect. Numerous researchers have documented that it is impossible to distinguish between home care applicants who would go to a nursing home, and those who would not, but come "out of the woodwork" for home care.

Illinois estimates that three (3) clients receive home and community-based services for each person deflected from institutional placement (3:1 ratio). Our case costs are approximately one-third the cost of nursing home placement. Consequently, we are able to serve two "woodwork" persons, in order to cover the one "true risk" client. We urge that the Federal regulations recognize the necessity of this strategy for home care programs.

In an effort to circumvent the "woodwork" problem, the regulations emphasize deinstitutionalization instead of deflection, penalizing early home care programs which focus on deflecting persons from institutional placement. In spite of the "woodwork effect", deflection continues to be the most effective method of cost savings. Deinstitutionalization is extraordinarily difficult, since most of the community supports have already given up. Further, any emphasis on deinstitutionalization must carefully distinguish between the normal discharge and the true deinstitutionalization.

We urge that the regulations recognize the difficulties of objective identification of risks on both deflection and deinstitutionalization, and that a waiver program should address both types of clients.

The regulations also require that a nursing home bed be available for each person served by the waiver program. This assumption is unrealistic and essentially requires a state to maintain increasing numbers of available, but empty beds. It is not likely that nursing homes will voluntarily hold beds empty since the economic impact would devastate the industry (if no payment was received). If a nursing home was reimbursed for holding the bed, payment would destroy any State savings. We urge that the Health Care Financing Administration (HCFA) recognize the unworkability of this requirement.

The new regulations distinguish between procedures/format for extension of current waivers and the award of new waivers. Clearly, HCFA is trying to change the rules in the middle of the game, making the criteria for new waivers much more stringent. While Illinois is concerned about the "new waiver" process, as a State with an existing waiver, we are more concerned about the extension requirements as they are being implemented. HCFA obviously prefers the "new waiver" requirements and has selected the amendment process as the means by which to force states with current waivers out of the extension process and into a new waiver application. Illinois, along with other states, has been placed in a "Catch-22". HCFA finds a small divergence from the approved waiver, and tells the State an amendment must be filed. Then, as a result of the amendment, the State is told that

an extension is inappropriate and that a new waiver must be submitted at the end of the three-year period. We urge that this "game playing" stop, and that amendments be allowed without forcing a State into a new waiver request.

Illinois' Special Concerns

The regulation's unworkability combined with HCFA's apparent harassment of States with pre-existing home care programs has brought unusual pressure to bear on the State of Illinois. Consequently, Illinois has had to address some unique issues which have interfered with management of the waiver program. These special issues are:

- . HCFA has stated that in some instances case costs are too low inferring that those clients were not in imminent risk of nursing home placement. Illinois' position is that these clients best represent the need for and purpose of the program. Without our home care program, these clients would have gone to a nursing home, at much greater cost. It is a clear advantage to pay \$80/month for more shopping assistance and chore services.
- . HCFA has argued that Illinois' definition of family, which is limited to legal responsibility, is not consistent with Federal regulation, but has failed to produce the Federal definition. Nevertheless, Illinois has been cited for allowing nieces and grandchildren to provide assistance. Illinois believes its current practice is consistent with Federal regulations.
- . HCFA has asked Illinois to have available on MIS daily service data, rather than monthly. The daily data are available at the local level for inspection. Collection at the central level would create an undue administrative burden and unnecessarily multiply the data base and effort data by thirty (30). Illinois believes it is far more appropriate and consistent with regulations for auditors to spot check the local data on a sample basis.
- . Illinois has been subjected to three (3) reviews/audits since May, 1984, throughout which no protocol or work plan has been made available to the four (4) agencies involved. The latest review being conducted by the Office of the Inspector General of the Department of Health and Human Services has no defined purpose beyond examining "cost effectiveness" and appears to be a "fishing" expedition.
- . The modified cost-effectiveness formula in the new Regulations is simplistic and fails to recognize deflection as a vehicle to shorten or delay institutional placement. Illinois' large state-funded contribution produces an overall savings which is unrecognized in HCFA's evaluation of "cost effectiveness".

Conclusion

In conclusion, Illinois fully supports the basic concept of a home and community-based service program to serve persons in imminent risk of unnecessary institution. We have a six-year history of a cost-effective program, with demonstrated savings to both the State and the Federal government. We are deeply concerned about the unnecessary bureaucratic hurdles that have been raised, believing they interfere with program management without a corresponding benefit.

After a thoughtful examination of options, Illinois recommends that the Committee consider incorporating the waiver program under the regular State Medicaid Plan, allowing each state the flexibility to develop cost effective programs that are consistent with the individual States' history and needs. Such action would remove us from the quasi-experimental approach HCFA has adopted towards the waiver program, changing its mind about requirements with each new bit of data, and would allow us to get down to the business at hand—cost effective, quality services for long term clients with a range of needs.

AGENCY OF HUMAN SERVICES
103 SOUTH MAIN STREET
WATERBURY, VERMONT 05676
(802) 241-2220



OFFICE OF THE SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

July 3, 1985

The Honorable Henry A. Waxman, Chairman
Subcommittee on Health and the Environment
2415 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Waxman:

I am writing to express our appreciation and support for your efforts to ensure that Medicaid beneficiaries who might otherwise require institutional care can benefit from home and community-based services as authorized by the Congress. Your Committee hearing of June 25, 1985, was an important step in identifying some of the significant problems which states have experienced in attempting to implement the provisions of Section 1915(c) of the Social Security Act.

Based on our own experiences and discussions with Medicaid officials in other states, we in Vermont are persuaded that a very different approach to the financing of long term care services for elderly and disabled citizens will need to be developed if we are to serve such individuals in humane, appropriate, and cost-effective environments. Specifically, we have seen that even when the Congress attempts to reduce the institutional bias of the Medicaid program (as it did with the enactment of the waiver program), states continue to have substantial difficulty in providing community-based services.

Several years ago, a number of proposals were suggested for converting the long term care components of Medicaid into a block grant program that would be administered by the states. Under such an approach, each state would have the flexibility to create an array of services that would best suit the needs of its citizens who require care and services for an extended period of time. Naturally, the initial grant amount would need to accurately reflect current federal spending on behalf of beneficiaries who would be covered under this program, and provisions would be required to annually adjust a state's grant for inflation. In addition, unlike other block grants which historically have not taken growth in population


AGING CORRECTIONS ECONOMIC OPPORTUNITY HEALTH
MENTAL HEALTH SOCIAL & REHABILITATION SERVICES SOCIAL WELFARE

served into account, it is imperative that legislation establishing a block grant for long term care include a periodic adjustment for demographic changes. It would also be imperative to maintain under non-block grant funding, each beneficiary's entitlement to acute medical services as was originally intended by Congress when it enacted the Medicaid legislation. From the state's perspective, there is an expectation that additional flexibility in designing and implementing its long term care system will greatly enhance the state's ability to provide necessary services for its elderly and disabled citizens.

It is our firm belief that the Medicaid program is urgently in need of fundamental reform if it is to be responsive to the growing demands of long term care for an ever-expanding group of elderly and disabled Americans. To that end, we ask that you consider approaches like the one described above, as a means of enabling state and federal governments to use their limited resources as efficiently as possible. Of course, we are prepared to assist in any efforts that would lead to a more responsive and effective Medicaid program.

Thank you for your attention to this most critical issue.

Sincerely,


Gretchen B. Morse, Secretary
Agency of Human Services

/taw

Medical Center

1055 Clermont Street
Denver CO 80220**Veterans
Administration**

July 3, 1985

In Reply Refer To: 554/111D

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
2415 Rayburn House Office Building
Washington, D.C. 20515

Attention: Mr. Andy Schneider

Dear Sir:

I am interested in providing my views to your Subcommittee on Health and the Environment in its consideration of Medicaid waivers authorized by the Omnibus Budget Reconciliation Act of 1981. As Chief of Geriatrics at the Denver Veterans Administration Medical Center, I have had the opportunity to work with many agencies whose goal is the provision of optimal care to our elderly citizens. As one initiative, Colorado has developed a home and community-based services program authorized by Colorado Senate Bills 138 and 119. This program provides a most needed service contribution in the long-term care continuum in our state. Many individuals who would otherwise require skilled nursing home care are able to remain in their home setting and receive appropriate services at a cost less than institutional care. In my view it is important for this type of service to enjoy expanded support. I am also aware that regulatory restrictions which require this program to operate under a waiver have limited the utility of this type of project. Were it possible for Colorado to support this program as a state option under its Medicaid authority would diminish the time and resources required to implement the waiver.

As a health professional I am concerned that people most in need of services be efficiently matched with available programs. As a taxpayer I am concerned that resources available be wisely used. I believe that allowing more latitude to the state in the administration of innovative programs such as Colorado's home and community-based program would help to accomplish both of these objectives.

Very sincerely,

Dennis W. Jahnigen
DENNIS W. JAHNIGEN, M.D.
Chief, Geriatrics



STATE OF NEBRASKA

ROBERT KERREY • GOVERNOR • HELEN BOOSALIS • DIRECTOR

July 5, 1985

Honorable Henry A. Waxman, Chairman
Subcommittee on Health and the Environment
2415 Rayburn House Building
Washington, D. C. 20515

Dear Congressman Waxman and Members of the Subcommittee on Health
and the Environment:

Thank you for the opportunity to comment on the home and community-based services
waiver regulations.

Although the State of Nebraska does not currently have a home and community-based
services waiver for older Nebraskans, we believe that the option for the waiver
system should be continued. The waivers have great potential in the area of
long-term care. They could facilitate substantial cost savings, greater
efficiency, and positive benefits to older individuals.

However, some problems exist in the current system. During the last three years
the regulations have been difficult to work with effectively. The rigidity
of the regulations leaves states with very little discretion. This prevents
states from functioning as effectively as they might. The March 13 regulations
have been particularly prohibitive to states in their work.

Due to the medical orientation of the Health Care Financing Administration,
the system is based on a medical model. The placement of more emphasis on a
service model, particularly community-based services, would be highly beneficial.

We are very much in favor of the home and community-based services waiver,
but we believe that the system should be studied and changes made to make the
system more responsive to the needs and concerns of older Americans and the
states applying for waivers.

Sincerely,

Patricia Kuehl
Deputy Director

PK/SU/mj

DEPARTMENT ON AGING, BOX 95044, LINCOLN, NEBRASKA 68509-5044, PHONE (402) 471-2306
AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER M/F/H



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P. O. Box 2675
HARRISBURG, PENNSYLVANIA 17105

WALTER W. COHEN
SECRETARY

(717) 787-2600/3600

July 8, 1985

The Honorable Henry A. Waxman
2418 Rayburn House Office Building
U.S. House of Representatives
Washington D.C. 20515

Dear Congressman Waxman:

When Pennsylvania first reviewed the interim regulations for home and community based services under 2176 Medicaid waivers late in 1981, we had great hopes that the Medicaid Program would begin to turn away from its bias toward financing institutional placement and allow States the flexibility to develop home and community based services for eligible beneficiaries.

In June 1982, The Pennsylvania Department of Public Welfare began to explore 2176 Medicaid waivers for persons with mental retardation. At that time, HCFA staff from the Philadelphia Regional Office were invited to explain the waiver requirements as contained in the interim regulations. Meetings were held through that November at which time the Department submitted its first waiver proposal for Philadelphia. The Department's second proposal covering Allegheny County was submitted in April, 1983. Over the three year term of these waivers (1983- 1986), the Department proposed to close 430 ICF/MR certified beds in State institutions and save \$3 million over the cost of institutionalized care. Services consisted of a comprehensive array of residential, day and support services.

The Secretary of Health and Human Services approved the Philadelphia Waiver in May, 1983 and the Allegheny proposal in January, 1984. Although some delays in approval were experienced, the approval process presented no extraordinary problems during that time.

Major problems surfaced after submission of four waiver proposals for Bucks, Chester, Montgomery and Delaware Counties in June, 1983. These waiver proposals followed the same format and included the same services, population and assurances as HCFA approved for the Philadelphia and Allegheny Waivers. Despite the fact that the waivers would have saved the Federal Government more than \$10 million over three years, HCFA adopted a distinctly negative tone toward the proposals. Unwritten policies, such as the requirement in April, 1984 that total waiver costs may not exceed 75% of the average cost of ICF/MR care, and demands for additional state assurances which were not required in regulation, became commonplace.

The proposals were finally disapproved in August, 1984. The reason given for the disapproval was that Pennsylvania had failed to meet its assurances under the approved Philadelphia Waiver based on an assessment which was done by Regional HCFA staff in June, 1984. We received the disapprovals of the four waiver proposals before the Department had an opportunity to review and comment on the assessment report, and in spite of the fact that HCFA staff had assured us that each waiver request would be judged on its own merits. The four denied proposals would have removed 144 beneficiaries from Medicaid beds and closed those beds and would have created 67 diversion beds.

Our approved waivers now include 430 beneficiaries (mentally retarded citizens) from State institutions and 30 diversion spaces. We have recently submitted waivers for Northeast and Central Pennsylvania for a total of 311 beneficiaries now in ICF/MR beds with those beds to close. If all of our waivers were approved, Pennsylvania would have targeted 885 beneficiaries from ICF/MR beds for community placement with the ICF/MR bed to be closed and 97 diversion beds.

In order to meet our commitments to close one of our mental retardation centers, we are now developing 124 additional ICF/MR beds that were never considered before we were denied approvals of the Bucks, Chester, Montgomery and Delaware County waiver requests. This expansion of Pennsylvania's private ICF/MR program will cost the Federal government six million more dollars than the waiver applications which were disapproved.

HCFA has also proved to be inconsistent in its review of amendments to waivers. On September 24, 1984, the Department submitted an amendment to the Allegheny Waiver to allow us to serve three children instead of three adults. The same type of amendment was approved for the Philadelphia waiver in September, 1984. The services for these children would not have increased costs, the number of clients, or any other aspect of the waiver. We received a disapproval letter for the amendment to the Allegheny Waiver on May 10, 1985, (seven and a half months later). The basis of the disapproval, as stated in the letter, was that the Department did not answer a question indicated in HCFA's December, 1984 letter regarding a separate cost breakout for children in two age ranges.

In fact, HCFA's December letter (attached) makes no such request. Our response to HCFA's earlier letter clearly asked that we be contacted if further clarifying information was needed. If a cost breakout request was HCFA's intent, they did not contact us for that outstanding data.

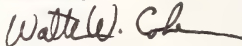
The latest blow to the viability of the waiver program, we fear, are the final HCFA regulations as published in the Federal Register on March 13, 1985.

Probably nowhere is the trend of undermining legislative intent more evident in the new regulations than in the limitation of waiver costs in the cost formula. Congress clearly intended that the cost effectiveness of the waivers would be demonstrated by comparing their cost against the cost of institutional care, not against estimates of cost which are technically inappropriate for setting cost ceilings. The resulting cap which is placed on federal financial participation will significantly erode the quality of home and community based services if not corrected. States should be required to provide services at a cost which does not exceed the cost of institutionalization, as indicated in the legislation. Relegating home and community based services to a "less costly" status, as the new regulations do, will result in less appropriate and less responsive community services. In fact, placing this fiscal constraint on community services will act as an incentive for States to continue to serve their mentally retarded citizens in much more costly facilities, thereby continuing the institutional bias which the 2176 waiver legislation was intended to correct.

Although Pennsylvania has had a less than satisfactory experience with HCFA's administration of our waiver requests over the past two years, we remain committed to the rights of people with mental retardation to receive appropriate services in the community and will not give up on seeing that community services become a real option in Pennsylvania. While we will continue to try and work with HCFA to reach reasonable solutions to the problems we indicated above, we are convinced that a long term solution is needed to provide a secure footing for home and community based services for persons requiring long term care.

Mr. Chairman, I appreciate this opportunity to share our experiences with the 2176 Waiver program with you, and respectfully ask that my letter be made a part of your hearing record.

Sincerely,



WALTER W. COHEN

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

1100 8066 Health Care Financing
Administration

020580

Refer To: DPO-R3(19)
File: 2-6-4-4iRegion III
P.O. Box 7760, 3535 Market St.
Philadelphia, PA 19101

DEC 21 1984

SECRET

DEC 24 2 09 PM '84

Walter M. Cohen
Secretary
Department of Public Welfare
Health and Welfare Building
Harrisburg, Pennsylvania 17120

R/S 563-84

RECEIVED
DEPT. OF PUBLIC WELFAREHowse
Baker
McKenna
Radke
file

Dear Mr. Cohen:

DUE: 1/11/85

We have reviewed Pennsylvania's September 24, 1984 request to amend its home and community based services waiver for Allegheny County which was approved on January 12, 1984 with an effective date of July 1, 1983. Under this amendment individuals under age 21 would become eligible under the waiver. Based upon our review, we have identified a number of issues which must be resolved and we find that we require the additional information included on the attachment to this letter.

Under Section 1915(f) of the Social Security Act, a waiver must be approved, disapproved, or additional information requested within 90 days of receipt or else the request will be deemed granted. The 90 day period in this case would have ended on December 26, 1984. However, based upon our timely request for additional information, a new 90 day period will begin upon our receipt of your response to this letter.

Please let me know if you need any clarification regarding the additional information which we are requesting. If you feel it would be helpful for members of our respective staffs to meet and discuss these points, I will be glad to arrange such a meeting. Finally, as soon as we receive the information requested herein, we will review it as expeditiously as possible.

Sincerely,

Everett F. Bryant
Regional Administrator

Enclosure

Request for Additional Information

On page 2, second paragraph of the amendment, Pennsylvania indicates that "to determine the amount the person must pay toward the cost of waived services, the Department, in accordance with provision 42 CFR 435.736 will deduct from the person's gross monthly income the following:" That statement is not entirely correct. We suggest the following wording: "the agency will reduce its payment for home and community-based services provided to an individual eligible under section 42 CFR 435.232 by deducting the following amounts from the individual's total income (including amounts disregarded in determining eligibility)." Please make this change to the amendment.

Pennsylvania states on page 2 of its approved request that waived services will be limited to mentally retarded individuals age 21-64. However, Pennsylvania now indicates that two individuals under age 21 have been placed in the waiver. Please be advised that FFP is not available for services provided these individuals since they are specifically excluded from participation in the approved Allegheny waiver. FFP would not be available until a final approval decision has been made on this waiver modification.

Pennsylvania assures us that "the amendment will require no other changes in waiver services, provider standards, number of beneficiaries or cost." We will need to know how many mentally retarded individuals aged 5-20 the State estimates will receive waiver services in the last 2 years of the request. We will also need to know the cost projections for these additional individuals because it appears they will receive less waived services than the over 21 age group.

There appear to be two specific groupings in the under 21 amendment, ages 5-16 and those 17 through age 20. Pennsylvania explains that the 5-16 age group would not receive adult day health services because they will be receiving public education funded through that Department. We would like to know what services this age group would receive while school is in session and during the summer recess. We would also like an explanation of what Pennsylvania means by "ages of 5 and 16 will not be receiving day services in DPW licensed day care facilities." Does this statement mean that these individuals could receive these services in unlicensed day care facilities? Please explain more fully.

Pennsylvania clearly will not provide the range and frequency of services to this new eligibility group as provided in the approved waiver request. All the services provided under a home and community-based waiver must not only be cost-effective but must also assist individuals to avoid institutionalization. The 5-16 age group will not receive any day services during the time that public school is in session. How then can waived services assist these

individuals to avoid institutionalization? We will require additional evidence demonstrating why individuals in this age group would, in fact, need institutionalization absent inclusion in the waiver. Pennsylvania must explain fully how the waived services will assist these individuals to avoid institutionalization. We will also need your assurance that absent the waived services, the under age 21 eligibility group would be institutionalized in an ICF/MR (42 CFR 441.301(b)(i)(ii)).



TARKY LOMBARDI, JR.
49th DISTRICT
CHAIRMAN
COMMITTEE ON HEALTH

THE SENATE
STATE OF NEW YORK
ALBANY
12247

July 9, 1985

The Honorable Henry A. Waxman
Chairman
Subcommittee on Health and the Environment
U.S. House of Representatives
2415 Rayburn House Office Building
Washington, D.C. 20570

Dear Representative Waxman:

As the developer of the Long Term Home Health Care Program (New York State's operating Home and Community Based Waiver), I have long recognized the potential of home and community based care to act as a cost-effective alternative to institutional care. If administered properly, home and community based service programs offer public policy makers a unique opportunity to meet the needs of the elderly and disabled, while reducing public and private health care expenditures. By offering institutionalized patients and those imminently at risk of institutionalization the Long Term Home Health Care Program, commonly known as Nursing Home Without Walls, we have allowed patients the option of remaining in their own homes with friends and family, motivating them to become more independent, and in some cases permitting them to die with dignity at home.

At the same time, the Long Term Home Health Care Program offers a substantial cost savings to public and private payors of long term care services by providing a lower cost alternative to nursing home care. The New York State Department of Social Services has stated that in 1983 the average Long Term Home Health Care patient had an annual Medicaid expenditure for all services of \$9,791, while the average nursing home patient had an average expenditure of \$21,081. This differential of more than 50% has remained quite constant since the program's inception seven years ago.

As New York faces a growing elderly and disabled population with attendant increased long term care costs, we have looked toward home care as a means to meet these escalating demands while lowering Medicaid costs. The Federal Home and Community Based Waiver Program and the flexibility it offers in terms of services and eligibility requirements is a vital part of our program to accomplish this goal. Recent New York State laws have been enacted directing the Commissioner of Social Services to seek 2176 waivers for severely physically and developmentally disabled children and elderly couples. However, I am deeply concerned that under the current climate, New York and other states will lack the flexibility to successfully implement Home and Community Based programs and weaken their ability to reduce long term care costs.

I ask for your support and assistance.

Kindest personal regards.

Sincerely,

Tarky Lombardi, Jr.

NEW YORK STATE

DEPARTMENT OF SOCIAL SERVICES

40 NORTH PEARL STREET, ALBANY, NEW YORK 12243

CESAR A. PERALES
Commissioner

New York State appreciates the opportunity to present testimony to the Subcommittee on Health and the Environment concerning the Home and Community Based Waivers authorized by Section 2176 of the Omnibus Reconciliation Act of 1981. New York has a strong commitment to the provision of home care services as an alternative to institutionalization. Our State has one of the largest Medicaid home care programs in the country and is currently participating in several home care demonstration projects (ACCESS, Social Health Maintenance Organization, Channeling, and the Long Term Home Health Care Program). Moreover, the Long Term Home Health Care Program (Nursing Home Without Walls) has served as the template for the 2176 waiver legislation. We, therefore, believe implementation of home and community based services is an important public policy issue that deserves the attention and scrutiny of the subcommittee.

We are aware that we are not alone in this concern. The Congress, HCFA, States, Health Care Providers, and the elderly, disabled and developmentally disabled recipients all have an investment in the implementation of the waiver provision and we believe share a common goal: the timely cost-effective implementation of the 2176 waivers. With this common goal in mind, we concur with several of the policy decisions that HCFA made in the process of implementing the Home and Community Based Services legislation. We find it appropriate and consistent with the legislation that the final regulations added acute care services to the formula which computes the average per capita expenditures under the waiver, and absent the waiver. We also fully support and agree with the application of the safety and other institutional standards contained in Section 1616(e) of the Act to Home and Community Based Services waivers.

However, the promise of the act has not been fulfilled and we object to several provisions in the new final regulations and to the way that HCFA has administered the waiver.

The new regulations contain several provisions which we believe are arbitrary and without basis in federal legislation. Specifically:

1. 441.302(e)(2) penalizes States whose actual expenditures for home and community based services under the waiver exceed their estimates by withdrawing FFP and potentially terminating the waiver. There is no legislative, programmatic or fiscal basis for this provision. Although a waiver may still be cost-effective with the average per capita costs under the waiver below what the average per capita costs would have been absent the waiver, a State may be penalized for failing to project accurately the growth of the program. As long as program expenditures are less than what would have been, without the waiver, we fail to see the rationale for "capping" a waiver based on estimates. This approach clearly encourages States to "pad" their original estimates, obscuring their best understanding of the program. We also object to the retroactive application of this cap to waivers that were approved prior to these regulations.
2. The final regulations (441.303(f)), require that States document their capacity to provide institutional care to those individuals who will receive home and community based services. According to the preamble to the regulations, HCFA will find "estimates unreasonable if the State does not have adequate bed capacity to institutionalize these individuals." As the State of Oregon pointed out in its letter to Secretary Heckler (Heckler; Hegstrom, 4/11/85); this requirement implies a one to one ratio between a nursing home bed capacity and home and community based services. Diverting or even de-institutionalizing a

recipient from institutional placement will not necessarily result in an empty bed. That empty bed is likely to be filled by a private paying patient or by a hospitalized patient awaiting nursing home placement. In a long term care system as large as New York State's, the impact of the waiver and its ability to deflect, while real, is certainly not a one to one trade off.

In New York, we are further concerned about how rigidly this regulation will be interpreted. We have a certificate of need methodology for determining the need for residential health care facility (RHCF) beds. Under this new methodology, 8 percent of a county or planning area's estimated need for residential health care facility beds must be met through the development or expansion of the long term home health care program (New York's operating 2176 waiver program). Under the new regulations, this will not provide adequate flexibility to continue to expand the program and substitute slots for inpatient beds.

3. 435.217 requires that individuals receive waived services, in order to be eligible for a waiver of the SSI deeming rules. This requirement is counterproductive in a State like New York with a sizable home and community based program under its State plan. This forces the State to provide a "waivered" service when the recipient may only need a waiver of SSI deeming rules to return home.
4. 441.302 limits waiver to one or any such group of the following: aged, disabled or both; mentally retarded or developmentally disabled or both; mentally ill. We see no legislative, programmatic or fiscal basis for arbitrarily limiting "mixed" waivers. It is entirely likely that target populations will not fit neatly into one of the three categories. States should have the flexibility to select their target populations in a way that is most meaningful to their constituency.

These objectionable regulatory provisions are not half as problematic as the way in which HCFA has administered the waiver. The process of obtaining the Secretary's approval is a confusing labyrinth of shifting rules, requests for additional information, and delays. If it was congressional intent to assure expeditious approval of the waivers by placing HCFA under a 90-day turn-around period, this intent has not been carried out. Based upon our experience and discussions with other States, few waivers, model as well as regular, are approved within the first 90 days. In our experience, the model waiver process is no shorter than the regular waiver process. Regardless of the type of waiver, there are always requests for additional information or new rulings at the end of the 90-day cycle. Moreover, many of these requests for additional information or ruling concern areas not addressed in regulations or guidelines available to States. For example, in our pending model waiver for severely disabled children, we expected to have some children who would receive services under the authority of both the model waiver and the State's original waiver (LTHHCP). Although the State assured HCFA that we would be able to isolate expenditures for each waiver, we were told that we could not "mix" the two waivers. Since there is no regulatory basis for this ruling, there is no way that we could have anticipated it.

Rather than alleviate this problem, the new regulations appear to offer HCFA many more places to arbitrarily interpret regulations. Currently, we are most concerned about HCFA's definition of what constitutes a request to extend an existing waiver and a new waiver. We plan to continue our Long Term Home Health Care Program virtually unchanged and submit it as an extension request in September. Yet, we are hearing from other States that HCFA is essentially considering all requests for extensions as new requests based upon what appear to be non-substantive changes. Although HCFA staff have offered assurances that our request will be considered an extension, other States' experience lead us to doubt

the reliability of these comments. This interpretation is crucial. If HCFA considers our request for an extension as a new request under the current regulations, New York State may lose federal Medicaid dollars for its waiver.

The new regulations require independent audits and assessments. At this point in time, none of the HCFA staff we have spoken to have any idea what would constitute a satisfactory audit or assessment.

As mentioned above, we are concerned about the type of documentation that HCFA will require to prove that our waiver programs are alternatives to institutionalization.

The bottom line, is that clients--the elderly, the disabled, mentally retarded and mentally ill--will not receive the services that Congress intended when it enacted Section 2176. The waiver has held out tantalizing hopes and promises to institutionalized individuals and their families. On a regular basis, we receive calls from parents of disabled children asking when they can take their children home. At this point, struggling with new regulations and the federal bureaucratic maze, we can only offer promises for the future.

What we are requesting is not unreasonable. We want our programs to be cost-effective. New York State cannot afford to expand home care unnecessarily and increase long term care expenditures. We are looking to 2176 waivers as a part of our program to target services to those most in need, to substitute home care for institutional care appropriately. In order for a home and community based waiver to be what it was intended to be, a program which provides the States with the flexibility to provide home care as an alternative to institutionalization, we need:

- o Withdrawal of the arbitrary provisions and interpretations in regulations mentioned above.
- o Clear-cut guidelines for other provisions (e.g., requirement for independent audit, assessment).
- o An expeditious review process for regular waivers.
- o A faster review process for model waivers.
- o The provision of accurate, fair, technical assistance to the States in the development of waivers.

We thank you again for the opportunity to present our thoughts on the Home and Community Based Waivers before the Subcommittee. Recognizing that the waivers have evolved into something much narrower and more rigid than originally envisioned, we would appreciate anything Congress can do to return to the States the flexibility they need to truly provide home and community based services as an alternative to institutionalization.

TESTIMONY

by

Arthur Y. Webb
Commissioner

New York State Office of Mental Retardation
and Developmental Disabilities

I. Introduction

The intent of the Medicaid home and community care waiver program was to allow states greater flexibility in administering their Medicaid programs and to benefit Medicaid recipients by funding alternatives to institutional care. The principle of offering community-based long-term care alternatives is one that is agreed to throughout the field of developmental disabilities. However, the requirements and administration of the waiver program has not supported states in their efforts to expand the service continuum to serve more individuals than are currently beneficiaries of the Medicaid program. Instead, the Health Care Financing Administration (HCFA) has used the waiver as a vehicle to restrict the growth of beneficiaries who are clearly entitled to Medicaid services from entering the Medicaid program. HCFA has also used the waiver as a vehicle to contain costs, thereby reducing federal expenditures.

The New York State Office of Mental Retardation and Developmental Disabilities chose not to participate in the Medicaid Waiver Program. We believed at the time that it would not facilitate our goal of continued expansion of home and community services within the developmental disabilities continuum of care. As we have watched the administration of this program and observed the negative impact it has had on service delivery in other states, we have realized our decision was indeed correct. I would like to take this opportunity to share with you our initial reservations and to suggest alternatives that you may want to consider in your deliberations.

II. New York State's System of Care and the Role of Medicaid in Financing the Continuum

First, let me provide an overview of the current MR/DD system in New York State and the future direction we foresee in terms of program expansion. In the early 1970's, great impetus was created to redirect the system away from institution service provision to community-based program alternatives. Pressure to do so was created as a result of civil rights federal court cases, and the initiative was reinforced by major federal statutes which articulated these rights and created new service modalities to better respond to the needs of handicapped citizens. While the initiative was there, sufficient federal funds were not available to support implementation. Only the Medicaid program with its categoric entitlement for the permanently handicapped, provided the potential for federal financial support to any meaningful degree.

New York State utilized this state administered program to further its efforts to return people to the community who had been institutionalized and to upgrade the quality of services for those individuals who remained in institutional settings. We now offer residential services to over 5,500 people living in community-based ICF/MRs. Over 26,000 individuals are served in the OMRDD residential continuum; 62% of these people are Medicaid beneficiaries. We have also elected to include Medicaid funded personal care services as a component of the family care program and plan to build a similar component into the community residence program. The availability of Medicaid has furthered the development of the day service continuum; OMRDD offers day treatment, which is Medicaid reimbursable to approximately 10,000 substantially disabled individuals who comprise more than 30% of all day service recipients. Without a doubt, the expansion of developmental disabilities services in New York State is directly attributable to the increase in federal financial participation through Medicaid. If this was unavailable, it is conceivable that the system of services would not have moved as dramatically as it has to community-based care. In summary, the Medicaid program has been used in New York State to reconfigure the service delivery system away from institutions and toward the community.

While we, as an agency, are pleased by our accomplishments, there remains a major service development task ahead of us. Our efforts to reduce the developmental center population will continue - 4,000 more institutionalized individuals will be placed into community settings over the next six years. At the same time, the energy and administrative commitment that have been devoted to deinstitutionalization must be rejuvenated so that our system can also expand the capacity to serve developmentally disabled persons who have remained at home with their families. This group includes young adults who are being graduated from the special education system and who need vocational training programs. It includes older mentally retarded persons with aging parents who can no longer provide consistent long-term care within the home. It also includes infants and young children who can benefit dramatically from early intervention services which lessen the long range effects of developmentally disabilities. In all cases, it is important for us to provide support services to the families of our clients so that their abilities to continue offering informal care is sustained. As evidence of OMRDD's commitment to this unserved population, we plan by 1991, to serve 9,000 more people in the community residential continuum and to double the number of persons who participate in day programs, which necessitates the development of habilitation and vocational training services for an additional 20,000 developmentally disabled adults.

III. New York State's reasons for not participating in the Waiver Program

There is a substantial unmet need for services to developmentally disabled people. As previously stated, Medicaid played a very significant role in the expansion of services. It is New York State's perspective that if we were to adopt a home and community care waiver, then the same role that Medicaid played in the past, would have to be played in the future. In other words, Medicaid, through the home and community care waiver, would have to serve our purposes in meeting the needs of the unserved and underserved. OMRDD needs to meet the demand for services in a responsible way. Medicaid assisted New York State in achieving that objective in the past. OMRDD would expect the same from the role of Medicaid in the future. However, as HCFA has chosen to interpret the formula used to determine approval of waiver requests, New York State would not have been able to use Medicaid under a home and community waiver program to further its goal to serve new beneficiaries.

What has become clear, as HCFA of the Department of Health and Human Services has progressed in its implementation of the home and community care waiver, is that HCFA interprets the waiver as a cost-containment vehicle. Yes, HCFA wants to encourage lower cost services and the effective use of Medicaid in the home and community-based environment. But through regulation and administrative interpretation, they use the regulatory formula in the waiver to assure that: (1) the average per capita cost after the waiver is less than the average per capita cost before the waiver, (2) the total aggregate cost after the waiver is less than the aggregate cost for services if the waiver services were not available, and (3) most importantly, the number of beneficiaries are limited to persons currently institutionalized or scheduled for imminent institutional placement. In summary, the waiver, as it is currently being implemented by the Health Care Financing Administration (HCFA), basically allows home and community-based services to only become available for people moving from institutions to the community, or those few for whom an institutional bed has been made available or capital construction has been planned. We do not believe that the institution should be viewed as the system's entry point. The interpretations of the formula creates a fiscal disincentive for states to use Medicaid as a vehicle to expand services to new recipients. This is the exact

opposite of many people's perceptions of what the home and community care waiver is intended to accomplish.

If a state's primary goal was to focus strictly on deinstitutionalization, the waiver program is unnecessary. New York State has substantially reduced the census in its developmental centers, in great part through the development of community ICF/MRs. Also, Medicaid has enhanced this system's ability to expand the day program continuum through the addition of day treatment services. Medicaid reimbursable personal care services allow more severely disabled individuals to live in family care homes and community residences. All of these program components have been added through existing options available as part of the State Medicaid Plan.

OMRDD did examine the nature of other services and programs that support families and clients who reside at home or in the lower cost out-of-home care programs that would be needed as the system grew to serve more people. Services, such as home care and home health care, are already Medicaid reimbursable, and New York State must only make decisions on the approach to making these services more generally available to persons with developmental disabilities. Other services, such as respite, family counseling, parent training, and crisis intervention, are generally relatively low cost services that require a high degree of flexibility in service delivery and management. OMRDD believes that existing regulatory requirements of Medicaid programs and the federal requirements for administration of the waiver are rigid and inflexible and may inhibit effective and flexible service delivery.

As part of our analysis of the program components which are necessary to expand the current service delivery continuum, we have reviewed the suitability of the community-based ICF/MR program as one of the residential options available to individuals with developmental disabilities. OMRDD believes that there is a role in the system of care for small ICF/MRs, and that this was the intent of Congress when it created this category of care within Title XIX (Medicaid) of the Social Security Act. We believe the current actions of HCFA, through the use of its regulatory formula, run counter to the intent of Congress to allow small ICF/MRs as a responsible option to large institutions for the care of the disabled.

OMRDD believes that, while the ICF/MR program provides the opportunity for appropriate intensive direct care and professional clinical services, certain federal regulatory requirements result in unnecessary extra cost. Mental retardation and developmental disabilities advocates across this nation have urged HCFA to modify the ICF/MR regulations so as to institute a more developmental and more normalizing concept in the ICF/MR program. In fact, staff of OMRDD have worked, through the National Association of State Mental Retardation Program Directors, with HCFA, on the development of alternative regulations which would do much to both improve the program and to lower cost. As previously stated, OMRDD does not believe that ICF/MRs are bad--quite the contrary. What is needed is an improvement in the federal Medicaid regulatory environment supporting the ICF/MR program. The community care waiver suggests that the remedy for the problems associated with ICF/MRs is to do away with them. OMRDD, on the other hand, believes that the remedy is regulatory change, and at the same time that the community care waiver was being implemented in many states, New York State was working to solve these problems through regulatory change. To this day, three years after the initiative began, HCFA has not published the regulatory changes that are believed necessary to improve care and to lower cost.

OMRDD is also committed to improve state administration of the ICF/MR program. Three years ago, OMRDD took action to improve the rate setting methodology for our community-based ICF/MR facilities. Our Agency has demonstrated greater cost efficiency in the system of services since the implementation of the new rate setting methodology.

In summary, if the community care waiver is seen as an approach to solve the problems with ICF/MRs, it represents the equivalent of throwing the baby out with the bath water. OMRDD's preference would be to correct ICF/MR problems through appropriate regulatory change that would give states the capacity to better manage this program.

IV. Recommendations for Modifications to the Home and Community-Based Services Waiver

- 1) Discontinue the waiver concept of the program and allow states to statutorily provide home and community-based services as an optional service within the State Plan.

We in New York State believe that there are viable approaches to cost containment and to an actual reduction in per capita costs. The approach that we would suggest would not jeopardize the quality of service delivery. In fact, the systems' ability to expand Medicaid coverage while controlling costs could be achieved if Medicaid were able to finance lower cost service options in the community.

We propose that the provisions of the Medicaid waiver for home and community-based services become a State Plan amendment option for each state if the total aggregate costs would remain lower than what they would have been without such an amendment.

It is our belief that Congress intended the waiver to promote greater efficiency (to promote lower cost service options) and greater effectiveness (to redirect savings to serve more people in these lower cost options). Regrettably, HCFA has not used the waiver to promote this intent. In essence, HCFA has stated that individuals moved to community programs from institutions had to be served for less money, but the State has not been allowed to apply the savings to program expansion for new eligible beneficiaries.

Congress also sought to increase State's discretion in determining the types of services to be offered. The purpose of the regulations governing the provisions of the Omnibus Budget Reconciliation Act (P.L. 97-35) was to give the states maximum opportunity for community service innovation with a minimum of federal regulation. Originally, HCFA announced in the Federal Register that state proposals would be evaluated according to statutory requirements rather than against a detailed set of federal regulatory criteria. The agency agreed that they would not mandate how a state should implement its community waiver program nor would it specifically define the allowable services. The states would be given broad discretion within overall budgetary constraints. Regrettably, current HCFA activity in the administration of waiver programs is not consistent with these concepts. In fact, the converse of these concepts seems to be the rule.

A State Plan amendment option would clarify Congressional intent of giving states discretion and ability to focus what was once institutionally expended dollars

for more clients receiving more appropriate community services. This option would create an incentive for states to continue deinstitutionalization and provide lower cost community services for new beneficiaries. States would be required to develop and meet certain standards of quality of care and live within an aggregate expenditure projection according to a fiscal formula that maintains both state and federal levels of expenditures but in a new configuration for more clients.

- 2) Authorize Medicaid to purchase prevocational and training (educational) services under certain conditions.

These services often provide optimal opportunities for growth and development and should be allowed as options under the Medical Assistance State Plan. They should not be disallowed as inappropriate settings for the provision of active treatment. What is really at issue is when it is appropriate for Medicaid to fund these services. We would suggest that Medicaid be considered the source of payment if these services are neither available nor paid for through existing state mechanisms in accordance with either PL 94-142 or the Vocational Rehabilitation Act.

- 3) Consider specific areas of regulatory relief within the ICF/MR program and channel HCFA's surveillance activities.

As we add services to the continuum that is funded by Medicaid, the suitability of the regulations governing this program must be revised. As they currently exist, the ICF/MR program regulations have a strong medical orientation. Historically, the medical model was the dominant approach in the MR/DD field. However, states have demonstrated the success of developmental programming as a suitable vehicle to enhance growth and skill development among developmentally disabled individuals. The regulations must be modified to reflect the progress that has been made in the field to better serve mentally retarded persons through services with a developmental orientation.

In addition to establishing a new fiscal and programmatic configuration, states still need to have relief from the drastic interventionist and surveillance functions HCFA is now imposing on states.

Much of the regulatory burden imposed by HCFA on New York results from the Secretary's broad authority to assess compliance and non-compliance under recently enacted "substantive look-behind" functions, (41 U.S.C. 1396(c)(1)(2) in addition to traditional "procedural" look-behind authority (42 C.F.R. 422.30). The traditional "procedural" look-behind authority given the Secretary has always enabled HCFA to be assured that New York, or any state, comply with federal procedural requirements in the licensing of ICF/MR programs. The traditional role of the state as the certifying authority was reflected in that structure.

The recent addition of "substantive" look-behind authority to the Secretary has led to a practice of federal interventionism on the programmatic as well as philosophic approaches to care-giving exhibited at the staff and program implementation levels within individual institutions within a number of states. This intervention has led to disagreements between the professional judgments of HCFA surveyors and those of the state surveyors. Many statutes can be amended to constructively and legitimately redirect the federal surveillance authority.

In particular, we would argue that a state plan agreement between the Secretary and participating states (42 C.F.R. 436.1(b)) should contain the standards governing the types and amount of services offered, to whom and where they are offered, and the standards for which the state would be held accountable, including methods, time frames and processes for determining state compliance. This simple mechanism would provide for greater stability to the existing system as well as a system emanating from a new State Plan amendment option. Once compliance standards are mutually agreed to, the federal government can focus its role on one of human and civil rights protection.

- 4) Provide broader authority to HCFA to approve administrative waivers to the states to demonstrate new systems of management and finance that are meant to enhance service delivery to developmentally disabled people.

In tandem with service delivery expansion, states need the opportunity, through federal incentives and support, to develop new administrative models that lead to greater cost-effectiveness and service quality. Currently, HCFA's ability to approve demonstration projects through the waiver authority is somewhat constrained. HCFA's authority to approve demonstrations must be broadened so that states may attempt new approaches to system's management, service configuration, and financing.

States should have the opportunity to develop innovative approaches to service delivery, financing, and program monitoring to meet the objectives of cost-containment, predictable financing, cost-efficiency and cost-effectiveness.

In conclusion, I would like to reaffirm New York State's commitment to Congress' original intent in establishing the home and community-based services waiver program and request that you strongly consider my recommendations to add home and community services as an option under the State Plan, expand the services offered, modify the regulations governing the program, and broaden the authority of HCFA to approve innovative administrative demonstration. States have clearly demonstrated, through the provision of innovative services, the capability of developmentally disabled individuals to thrive in community settings. Changes can be made in the Medicaid program to formalize the original goals of congressional action. States can then more reasonably expand the availability of home and community-based services to both beneficiaries and persons leaving institutions while assuring predictable growth in expenditures and cost-efficiency throughout the program.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

John A. Graham, Executive Director

STATE CAPITOL, BISMARCK, ND 58505
Telephone: (701) 224-2310



George A. Sinner
Governor

July 9, 1985

ECONOMIC ASSISTANCE
MEDICAL SERVICES
VOC. REHAB. SERVICES
HUMAN SERVICES

*Alcoholism & Drug Abuse Services
Developmental Disabilities
Mental Health Services
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HUMAN SERVICE CENTERS

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The Honorable Henry A. Waxman, Chairman
Subcommittee on Health and the Environment
House Committee on Energy and Commerce
Room 2424, Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Waxman:

I am pleased that your subcommittee is taking the opportunity to review federal administration of the Medicaid home and community care program. As Executive Director of the North Dakota Department of Human Services, I wish to express my concerns about problems I foresee under the current Medicaid process when the currently approved North Dakota waiver programs for developmentally disabled persons must be renewed.

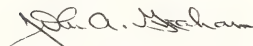
It appears that application of the present HCFA review process in other states (i.e., Oregon, Florida), if applied to North Dakota, may result in defaulting on commitments we have to developmentally disabled persons served under the present waiver. Our state legislature has doubled our state appropriation premised on our approved initial waiver. Re-interpretation as presently applied by HCFA undermines our good faith state commitment.

It appears that HCFA is attempting to apply a process to determine eligible services rather than defining the parameters of professionally defined reimbursable services. This ambiguity leaves those of us responsible for state planning in a most tenuous position.

Health and Human Services did not provide states the opportunity to comment on the regulations published on March 13, 1985, prior to implementation. I am convinced that a more workable set of program rules would have resulted had HHS solicited input from the interested public before developing and publishing these rules.

I respectfully request that your subcommittee review and adopt the recommendations submitted in testimony by the Medicaid Task Force of the Consortium for Citizens with Developmental Disabilities. I believe it is imperative that states, such as North Dakota remain able to respond to the needs of our developmentally disabled citizens. Your subcommittee recommendations are a vital component of that commitment.

Sincerely,


John A. Graham
Executive Director

cc: Representative Byron Dorgan
Senator Mark Andrews
Senator Quentin Burdick

DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 4210

STATE OF MONTANA

HELENA, MONTANA 59604

July 10, 1985

The Honorable Henry A. Waxman, Chairman
Subcommittee on Health and the Environment
Health Committee on Energy and Commerce
Room 2424, Rayburn House Office Building
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Waxman:

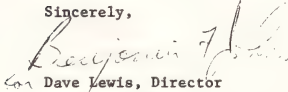
The State of Montana has been involved in the Medicaid home and community-based care waiver program since December, 1981. To the benefit of Montana's citizens who require special care, the program has become a cost-effective alternative to institutional care. For example, approximately seventy (70) developmentally disabled citizens have been able to move from institutional settings into community living arrangements that allow more fulfilling and normalized lifestyles. An approximately forty (40) children have also been diverted from institutions and been able to stay in natural or foster family settings through the flexibility in home-based services allowed under our waiver program.

I believe the enhanced quality of life for these folks, made possible through the efforts of those both at the state and federal levels, is an extremely important undertaking that should not be undermined through unnecessary regulation. The recent activities of both the OMB and HCFA, in particular the recently published regulations for the waiver program, have resulted in an inappropriate, cumbersome maze of data requirements, without proper regard for states' unique demographic characteristics. States are also finding the maximum bed capacity element of the cost formula acting as a disincentive to closing institution beds.

I strongly urge your continued investigation of issues in this arena, and support of the statement of testimony offered by the Consortium for Citizens with Developmental Disabilities (June 24, 1985). This statement provides positive directions for change to help salvage a promising program for needy citizens. Montana is a state whose

constituents have benefitted from the waiver program and whose administration met the test of cost-effectiveness. It is my sincere hope that you and others in a position to influence the operating practices of OMB and HCFA can impact on behalf of the states and will do so.

Sincerely,



for Dave Lewis, Director
Social and Rehabilitation Services

cc: Lee Tickell
Mike Muszkiewicz
Linda Poniktera
Lowell Uda
Robert M. Gettings

DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES



TED SCHWINDEN, GOVERNOR

P.O. BOX 4210

STATE OF MONTANA

HELENA, MONTANA 59604

July 10, 1985

Honorable Henry A. Waxman
Chairman, Subcommittee on Health and Environment
2415 Rayburn House
Washington, D.C. 20515

Dear Congressman Waxman:

The Montana Department of Social and Rehabilitation Services welcomes the opportunity to present its position regarding the Medicaid waiver program as a whole as well as the proposed regulations that have been prepared by the Department of Health and Human Services.

Montana has experienced very good results from the Medicaid waiver and the operation of this program to date. These positive findings are in the form of both fiscal results and program benefits for elderly Montana citizens.

On a per capita average, nursing home rates in Montana are currently \$16,500 per year. As in other states, roughly two-thirds of these individuals are Medicaid recipients. While the waiver program is still in its formative stages, costs for long term care under the waiver have stabilized at just over \$6,000 on an annualized basis. This represents a considerable cost savings for both federal and state public funds.

Montana has a very strict and tight entrance screening requirement. This exact same screening is mandated for Medicaid recipients for nursing home admission as well as admission to the waiver program. It is our assertion, and one that can be documented, that these individuals are identical. This is not a new client group. About 40% have been discharged from an institutional setting. The remaining individuals have been diverted from institutional long term care with resultant costs associated with this care.

On a program basis, surveys that have been conducted strongly demonstrate the wish and the desire of this elderly and disabled population to remain in their own homes. It has been highly satisfying to assist in maintaining individuals who have a strong desire to remain independent and to remain out of an institutional setting wherever possible.

Montana, with its disabled population, has been a strong advocate of deinstitutionalization over the past several years. We view the waiver program as a continuation of the trend for deinstitutionalization, and we strongly support the continuation of federal participation in this crucial activity for our elderly and for our disabled population.

To assist in the further development of the Home and Community Services Program, we are highly supportive of Senate Bill 1277 that has recently been introduced by Senators Bradley, Chiles and Glenn. It is our position that this program can be more effectively operated and strengthened by allowing states the opportunity to exercise the option of Home and Community Services as a Medicaid service as opposed to the continuation of these services via the current waiver mechanism.

We feel that this incorporation of Home and Community Services as an optional Medicaid service would be in conformance with Congressional intent. The preamble to the proposed regulations states "...Congress intended to give the states maximum flexibility in operating the waiver programs." The various states have demonstrated a high degree of commitment to the Home and Community Services program; this commitment can be strengthened by the continuation of Congressional action to maintain flexibility in the operation of the program.

There seems to have been some confusion regarding the new regulations and the interpretation of these regulations. Among the specifics of the new regulations, of concern to Montana are:

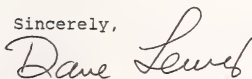
- . the difference between what constitutes a "new" waiver and what may be considered an amendment to an existing waiver. This issue currently is facing Montana in some technical amendments that need to be incorporated into the existing waiver.
- . the cost formula in which the total expenditures may not exceed the approved estimates for these services. Our initial understanding of Congressional intent was that savings achieved could be utilized by the state to cover the costs of an identical population in the community setting.

- . the one-to-one ratio assumed in the regulations for nursing home bed utilization and community placement. Preliminary data in Montana indicates that this ratio would more accurately be approximately 2.5 to 1.
- . federal reporting requirements in some instances are not clear as to the intent for the documentation and in some instances impossible without setting-up improbable barriers for the delivery of home services to elderly and disabled individuals.

These are among our current concerns for which policy and regulatory clarification are sought. Montana, as well as other states who operate Home and Community Services programs, desires that all involved participants have a common set of guidelines, policies, and regulations. This includes Congress, the states, and the Department of Health and Human Services. We welcome this hearing as a positive development to assist in this task of a more common understanding of Congressional intent, federal regulatory requirements, and the program operations of the states.

Montana would also like to take this opportunity to invite you, members of the Subcommittee on Health and the Environment, and any staff members to the Third National Conference on Home and Community Services. We expect delegations from 45 to 47 of the states to attend this conference. The agenda will reflect many of these same issues being addressed by the Subcommittee. This conference will be hosted by Montana in Kalispell, Montana, September 29 through October 2, 1985. We welcome you to attend.

Sincerely,



Dave Lewis, Director
Montana Department of Social and Rehabilitation Services



State of Wisconsin

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

1 West Wilson Street, Madison, Wisconsin 53702

Anthony S. Earl
Governor

July 11, 1985

Linda Reivitz
Secretary

Mailing Address:
Post Office Box 7850
Madison, WI 53707

Congressman Henry A. Waxman
Chairman
Subcommittee on Health and the Environment
House Committee on Energy and Commerce
Rayburn House Office Building - Rm. 2424
U. S. House of Representatives
Washington, D.C. 20515

Dear Congressman Waxman:

The State of Wisconsin would like to join in the support of the Medicaid Home and Community Care Waiver Program. This waiver has provided the option of home and community-based services for persons who otherwise would have only the alternative of institutional care. While we believe the intent of this program is excellent, we have several concerns about the final regulations.

The limitations imposed by HCFA on the number of waiver eligible persons, as well as the review criteria used to determine this number, have resulted in a less effective program than intended. The requirement that states must provide evidence of additional bed capacity in order to justify the diversion of people who without the waiver would be institutionalized, results in keeping a maximum number of beds available to cover the people the states wish to divert. In effect, states are forced into simultaneously building bed capacity and expanding services through a waiver. This is obviously not cost-effective and has penalized states that have done a good job of containing costs through moratoria on new institutional beds.

In addition to limiting the waiver eligible persons in relation to bed capacity, HCFA has also required states to stay within this estimated number even if total costs are less than originally projected. Since an intent of the waiver was to reduce overall Medicaid costs, states should not be penalized for serving more people while still meeting the eligibility and cost-effectiveness requirements of the program.

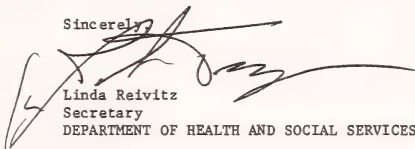
Another area of concern is the HCFA interpretation of what constitutes legitimate claims for habilitation services. The regulations state no reimbursement will be made for vocational and educational services but no clear-cut definitions of what constitutes these services exist. Additionally, HCFA erroneously believes that pre-vocational and vocational services are "not commonly furnished as a means of avoiding institutionalization." Many studies have shown that meaningful daytime services (including educational, pre-vocational and vocational training) are a key to successful community care. Additionally, denying persons with disabilities the

opportunities to engage in meaningful, valued work and gain esteem and self-sufficiency goes counter to all HCFA's efforts to decrease the dependency of persons with disabilities.

The final major area of concern is HCFA's process for reviewing and approving waiver requests. Despite the publication of the final waiver regulations March 13, considerable ambiguity still remains as to the criteria HCFA uses in evaluating waiver applications and renewals. The regulations, while spelling out the process and procedures HCFA uses in reviewing waivers, do not detail the operational guidelines for determining what exactly is an acceptable waiver. Wide variations exist across states as to what has been acceptable in terms of the number and type of eligible participants, services and cost-effectiveness of the programs. HCFA must issue clear criteria for reviewing and renewing waivers in order that states can more effectively develop and implement their programs.

We urge you to bring forth our concerns in order to improve what we believe is an excellent program that has enhanced the options and quality of life for persons who otherwise would only have the option of institutional care.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Linda Reilvitz', is written over the typed name and title. The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Linda Reilvitz
Secretary

DEPARTMENT OF HEALTH AND SOCIAL SERVICES



COMMONWEALTH of VIRGINIA

JOSEPH J. BEVILACQUA, Ph. D.
COMMISSIONER

Department of
Mental Health and Mental Retardation

MAILING ADDRESS
P.O. BOX 1797
RICHMOND, VA. 23214

July 15, 1985

The Honorable Henry A. Waxman, Chairman
Subcommittee on Health and the
Environment
House Committee on Energy and Commerce
Room 2424
Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Waxman:

We are supportive of the provision to the Social Security Act which permits States under certain circumstances to furnish Medicaid Reimbursable Home and Community Care Services to eligible recipients who otherwise would require long term care in medicaid-certified facilities. The Federal Government has granted States increased flexibility to address long term care needs of low income elderly and disabled persons. This provision gives States an opportunity to serve more disabled persons in community programs.

There are several major areas of the provision that we would like to address in our testimony on the Medicaid Home and Community Care Waiver Regulations. The first is:

1. Limitations on the number of eligible recipients

A State is required to furnish detailed documentation regarding the current number of medicaid-certified beds in SNFs, ICFs and ICF/MRs along with evidence of the need for additional bed capacity of present certified beds. A State is obligated to produce convincing evidence that new facilities would be constructed and certified in the absence of the proposed waiver; (e.g. approved certificate of need requests; capital appropriations for new/expanded facilities). States must furnish data on (a) the occupancy rate of medicaid-certified SNF, ICF, and ICF/MR beds by type including any excess beds capacity by type (b) waiting lists for admissions to certified facilities by type; and (c) the number of waiver clients actually being deinstitutionalized versus those diverted from admission.

We find this method to be too restrictive. States are precluded from reinvesting any savings that they receive. HCFA should permit States to finance expanded diversionary programs for at risk populations through the use of savings achieved through shifting current institutionalized residents to less expensive home and community-based settings by providing community-based services vs. institutional settings. States are now more apt to restrict services to recipients who require more extensive and costly array of community-based services.

2. Limitations on covered services

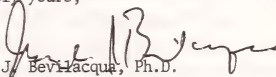
In the preamble to the recently published final regulations, HCFA states that prevocational/vocational training and educational activities are not reimbursable under a home and community-based care waiver. Deinstitutionalization efforts are tied directly to the development of increased prevocational and vocational opportunity. Access to appropriate day services is an absolutely essential pre-requisite to successfully serving persons with developmental disabilities in community settings. We know of no State that does not include access to appropriate day program (i.e. prevocational/vocational service) as a pre-condition to receiving residential services in the community.

HCFA has never indicated how they expect States to distinguish between habilitation, education, vocational/prevocational training for medicaid reimbursement. We would like to see the regulations amended to include habilitation and prevocational/vocational services as a medicaid community-based care service. It is important to note that developmentally disabled persons can be trained to be productive employees if they are offered appropriate social supports and an environment tailored to their particular needs and capabilities.

The Department of Mental Health and Mental Retardation appreciates the opportunity to bring the State of Virginia's views to the Subcommittee. If we can be of further assistance do not hesitate to contact me.

With kindest regards, I am

Sincerely yours,


Joseph J. Bevilacqua, Ph.D.
Commissioner

JJB/SGR/mm/F1

cc: Carol Singer-Metz



MSF

Minnesota Senior Federation

301 FULLER—SUITE No. 2
ST. PAUL, MINNESOTA 55103
(612) 227-4836

REGIONS:

*Central Senior Federation

*Iron Range Senior Federation

*Metropolitan Senior Federation

*Minnesota Valley Senior Federation

*Northwest Senior Federation

*Senior Citizens Coalition of N. E. Minnesota

*Seven County Senior Federation

*South Central Minnesota Senior Federation

*S. E. Minnesota Senior Citizen Organization

*South West Senior Coalition

*West Central Senior Federation

*Northern Lakes Senior Federation

My name is Grace Nelson, former president of the Minnesota Senior Federation and current chair of its Long Term Care Committee.

The Minnesota Senior Federation, with a membership of over 150,000, is actively and effectively engaged in issues that concern seniors and all of society.

We seniors want to stay in our homes. Our organization began in the 1970's to emphasize this fact by becoming actively engaged in advocacy for home care services. We were involved in the initiation of the Preadmission Screening and Alternative Care Grant Program and have continued active support for the program. Why? Because it is cost effective and at the same time satisfies our heartfelt desire to stay in our homes.

Before going further, let me briefly describe our PAS/ACG Program. The program began as a pilot project in two counties and is now required in all counties.

All elderly applicants to nursing homes who are 65 or over and are eligible for Medicaid or will be 180 days are required to be screened by the County's preadmission screening team consisting of a social worker, a nurse, and a doctor on call. The screening team makes a recommendation as to placement. The client has the final choice.

The Alternative Care Grant Program can fund services to individuals screened which will allow them to stay in their home rather than enter a nursing home.

Now, may I share with you firsthand current examples of the implementation of the program. All clients are on Medicaid and as such the Medicaid waiver currently covers 50.3% of the costs of home care services.

Paul and Tess Schneider were on the verge of entering a nursing home. She was wheelchair bound with osteo-arthritis

and had very limited vision resulting from unsuccessful cataract surgery. Paul had alzheimers related disease. Tess heard about the Preadmission Screening Alternative Grant Program. They entered the program and now continue to enjoy their home, their friends and their dog. As an added plus for Tess, the program has made it possible for her husband to be cared for at home while she had successful corrective cataract surgery. Now, she has almost full vision and as she says, "a new life". The cost of care comes to \$1,420 a month for the two of them. In a nursing home it would be at least \$3,192.

Mae Wohlers was bedridden with diabetes and cancer for the last two and one-half years of her life. Her husband assisted with the help of a home health aide for two hours a day was able to keep her at home until she died. The cost of care was \$483 a month compared to \$1890 a month in a nursing home.

A son and daughter are providing a home with them for their elderly parents who are candidates for a nursing home skilled care. With the help of a home health aide for two hours twice a week and respite care for two weeks once a year, the parents can remain with their children. The cost averages to \$240 a month at home, in a nursing home, \$3780.

A daughter and son-in-law have her mother, who is confined to a wheelchair and needs total care, living with them. The daughter leaves for work at 9:00 o'clock; the son-in-law comes home from work at 3:30. A homemaker comes in at 8:30 and stays until 3:30. The cost is \$890.40 a month compared to \$1895 in a nursing home. Both can work and the mother is where she wants to be.

Sharon Cushey's mother-in-law was in a nursing home. Now she is with them in an apartment in their home. Caring for her mother-in-law who needs almost complete care brought on a stress related illness. Then Sharon learned about PAS/ACG Program and help resulted. The mother-in-law has adult day care service 5 days a week, a homemaker once a week and respite care over an occasional weekend. The cost is an average of \$258 per month compared to \$1890 in a nursing home.

These examples which are typical, illustrate the value the dollar has in the purchase of home care services. They also illustrate the need for the support of the family care givers. Just consider the dollar value given by these family members over the twenty-four hour day and the subsequent saving in Medicaid dollars.

Medicaid waivers represent money well spent and are essential to the funding of the PAS/ACG Program. These waivers must also continue to cover the social services - services which are so essential.

We would also urge that serious consideration be given to have Medicaid automatically cover social services so that waivers would not be required.

Thank you.

DEFICIT REDUCTION PROPOSALS: PART B OF MEDICARE

WEDNESDAY, JULY 17, 1985

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:19 p.m., in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. We are meeting today to consider proposals for the fiscal year 1986 budget that affects part B of Medicare. We do not have agreement yet with the Senate on a budget resolution. However, we believe it is prudent to proceed with developing our budget proposals using the House budget resolution as a guide.

The first concurrent budget resolution passed by the House earlier this year calls for a total savings in Medicare of \$3.4 billion in fiscal year 1986 and \$13.1 billion over 3 years. These figures are for both part A and part B of Medicare and are assigned to both this committee and the Committee on Ways and Means without differentiation as to how much is to be achieved under part A or part B or how much is to be achieved by either committee.

While it is clear that much of the targeted amount will have to be achieved under part A, which is the jurisdiction of Ways and Means, it is also clear that we share responsibilities for meeting the target with savings under part B.

As it has in the past, the Budget Committee has also instructed us to achieve these savings without decreasing benefits or increasing the costs borne by the beneficiaries. I fully expect this committee to abide by that directive, as it has done so in the past. We will do so because it represents fair treatment for the beneficiaries who rely on Medicare.

Medicare beneficiaries are already saddled with onerous cost-sharing requirements. In addition to a \$400 part A deductible and a \$75 part B deductible, they have to meet the part B premium of \$15.50 per month and copayments on extended hospital and nursing home stays as well as the 20 percent coinsurance on physician services and other part B services.

They are also responsible for substantial out-of-pocket expenses averaging nearly 30 percent for the total bill when physicians do not agree to accept assignment. The burden of these cost-sharing requirements is compounded by the coverage limitations of the Medicare Program. Program benefits are far from comprehensive,

with noteworthy gaps in coverage for prescription drugs, vision care, and early detection and preventive care for chronic diseases.

Efforts to make substantial reductions in Medicare outlays are not new. Over the past 5 years we have made reductions totalling more than \$20 billion. Any easy solutions have long since been exhausted. Any further reductions are going to come only with difficulty and with objections from at least some of the affected parties.

The administration has not yet submitted its proposals to us for consideration, although we have certainly heard a good bit about what these proposals are likely to be. From what we hear, many of them will be objectionable because they reduce benefits, increase beneficiary cost sharing, or otherwise impact adversely on beneficiaries.

The purpose of this hearing today is to hear from a variety of knowledgeable and interested parties and organizations with suggestions for budget reductions, refinements in the provisions enacted last year, or other improvements in the program.

I know they are all interested in helping us solve our dilemma as effortlessly and painlessly as possible, and we look forward to hearing from all of the witnesses we have scheduled.

Without objection I would like to put in the record the text of H.R. 2293, H.R. 2864, H.R. 2342, H.R. 2807, and H.R. 2703 and any reports thereto.

[The bills referred to follow:]

[Testimony resumes on p. 412.]

99TH CONGRESS
1ST SESSION

H. R. 2293

To amend title XVIII of the Social Security Act with respect to the establishment of standards for long-term health care insurance.

IN THE HOUSE OF REPRESENTATIVES

APRIL 30, 1985

Mr. WYDEN introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

A BILL

To amend title XVIII of the Social Security Act with respect to the establishment of standards for long-term health care insurance.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. SHORT TITLE.

4 This Act may be cited as the "Long Term Care Insur-
5 ance Promotion and Protection Act of 1985".

6 SEC. 2. MEDICARE AMENDMENT.

7 Section 1882 of the Social Security Act (42 U.S.C.
8 1395ss) is amended—

2

1 (1) by inserting “or long-term health care policies
2 (as defined in subsection (k)(4))” in subsection (j) after
3 “medicare supplemental policies”, and

4 (2) by adding at the end the following new sub-
5 section:

6 “(k) STANDARDS FOR REGULATION OF LONG-TERM
7 HEALTH CARE POLICIES.—(1) The Secretary shall, in con-
8 sultation with Federal and State regulatory agencies, the Na-
9 tional Association of Insurance Commissioners, private insur-
10 ers, organizations representing consumers and the aged, and
11 providers of long-term health care services, establish model
12 standards for the regulation of long-term health care policies
13 not later than one year after the date of the enactment of this
14 subsection. Such standards shall be designed (A) to limit mar-
15 keting and agent abuse, (B) to assure the dissemination of
16 such information to individuals entitled to benefits under this
17 title (and to other consumers) as is necessary to permit in-
18 formed choice, (C) to promote policies which provide reasona-
19 ble economic benefits for such individuals, (D) to reduce the
20 purchase of unnecessary duplicative coverage, and (E) to im-
21 prove price competition.

22 “(2) Once the standards are established under paragraph
23 (1), subsections (a) through (e) of this section shall apply to
24 long-term health care policies (as defined in paragraph (4)) in

1 the same manner as they apply to medicare supplemental
2 policies, and for this purpose—

3 “(A) any reference to a medicare supplemental
4 policy is deemed a reference to a long-term health care
5 policy;

6 “(B) any reference to the NAIC Model Standards
7 is deemed a reference to the standards established by
8 the Secretary under paragraph (1) and any reference to
9 a specified percent in subsection (c)(2) is deemed a ref-
10 erence to a percent specified in such standards; and

11 “(C) any reference to a date is deemed a refer-
12 ence to a corresponding date specified by the Secretary
13 by regulation.

14 “(3) The Secretary shall include in the biannual report
15 submitted under subsection (f)(2)—

16 “(A) a periodic assessment of actions taken by
17 States and by the Secretary to regulate the offering of
18 long-term health care policies, and

19 “(B) appropriate recommendations for legislative
20 or administrative changes needed to secure consumer
21 protection in the area of long-term health care policies.

22 “(4) For purposes of this subsection, a long-term health
23 care policy is a health insurance policy or other health benefit
24 plan offered by a private entity to individuals who are enti-
25 tled to have payment made under this title, which provides,

1 or provides reimbursement for expenses incurred for, long-
2 term health care services (as defined by the Secretary and
3 including home health services, skilled nursing facility serv-
4 ice, and intermediate care facility services) that are provided
5 over a period of at least six months; but does not include any
6 such policy or plan of one or more employers or labor organi-
7 zations, or of the trustees of a fund established by one or
8 more employers or labor organizations (or combination
9 thereof), for employees or former employees (or combination
10 thereof) or for members or former members (or combination
11 thereof) of the labor organizations.”.

99TH CONGRESS
1ST SESSION

H. R. 2864

To amend title XVIII of the Social Security Act with respect to administrative and judicial review of determinations under that title.

IN THE HOUSE OF REPRESENTATIVES

JUNE 25, 1985

Mr. WYDEN introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

A BILL

To amend title XVIII of the Social Security Act with respect to administrative and judicial review of determinations under that title.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Fair Medicare Appeals
5 Act of 1985".

6 **SEC. 2. CHANGING MEDICARE APPEAL RIGHTS.**

7 (a) **PERMITTING PROVIDER REPRESENTATION OF**
8 **BENEFICIARIES.**—Section 1869(b)(1) of the Social Security
9 Act (42 U.S.C. 1395ff(b)(1)) is amended by adding at the end
10 the following new sentence: "Sections 206(a), 1102, and

1 1871 shall not be construed as authorizing the Secretary to
2 prohibit an individual from being represented under this sub-
3 section by a person that furnishes or supplies the individual,
4 directly or indirectly, with services or items solely on the
5 basis that the person furnishes or supplies the individual with
6 such a service or item.”.

7 (b) REVIEW OF PART B DETERMINATIONS.—(1) Sec-
8 tion 1869 of such Act (42 U.S.C. 1395ff) is further
9 amended—

10 (A) by inserting “or part B” in subsection (a)
11 after “amount of benefits under part A”,

12 (B) by inserting “or part B” in subsection
13 (b)(1)(C) after “part A”, and

14 (C) by amending paragraph (2) of subsection (b) to
15 read as follows:

16 “(2) Notwithstanding paragraph (1)(C), in the case of a
17 claim arising—

18 “(A) under part A, a hearing shall not be avail-
19 able to an individual under paragraph (1)(C) if the
20 amount in controversy is less than \$100 and judicial
21 review shall not be available to the individual under
22 that paragraph if the amount in controversy is less
23 than \$1,000; or

24 “(B) under part B, a hearing shall not be avail-
25 able to an individual under paragraph (1)(C) if the

1 amount in controversy is less than \$500 and judicial
2 review shall not be available to the individual under
3 that paragraph if the aggregate amount in controversy
4 is less than \$1,000.

5 In determining the amount in controversy, the Secretary,
6 under regulations, shall allow two or more claims to be ag-
7 gregated if the claims involve the delivery of similar or relat-
8 ed services to the same individual or involve common issues
9 of law and fact arising from services furnished to two or more
10 individuals.”.

11 (2) Section 1842(b)(3)(C) of such Act (42 U.S.C.
12 1395u(b)(3)(C)) is amended by striking out “\$100 or more”
13 and inserting in lieu thereof “at least \$100, but not more
14 than \$500,”.

15 (3) Section 1879(d) of such Act (42 U.S.C. 1395pp(d)) is
16 amended by striking out “section 1869(b)” and all that fol-
17 lows through “part B)” and inserting in lieu thereof “sections
18 1869(b) and 1842(b)(3)(C) (as may be applicable)”.

19 (c) EFFECTIVE DATES.—(1) The amendment made by
20 subsection (a) takes effect on the date of the enactment of this
21 Act.

22 (2) The amendments made by subsection (b) shall apply
23 to claims submitted on or after October 1, 1985.

99TH CONGRESS
1ST SESSION

H. R. 2342

To amend part B of title XVIII of the Social Security Act with respect to vision care under the medicare program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 2, 1985

Ms. MIKULSKI (for herself, Mr. ROYBAL, Mr. WHITTAKER, Mr. SCHEUER, Mr. WIRTH, Mr. FLORIO, Mr. MADIGAN, Mr. SIKORSKI, Mr. LELAND, Mr. STOKES, Mrs. COLLINS, Mr. TAUKE, Mrs. LLOYD, Mr. KOLTER, Mr. FORD of Tennessee, Mr. DANNEMEYER, and Mr. ECKART of Ohio) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

A BILL

To amend part B of title XVIII of the Social Security Act with respect to vision care under the medicare program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. SHORT TITLE.

4 This Act may be cited as the "Medicare Vision Reform
5 Act of 1985".

6 SEC. 2. VISION CARE UNDER MEDICARE PROGRAM.

7 (a) DEFINING SERVICES AN OPTOMETRIST CAN PRO-

8 VIDE.—Clause (4) of section 1861(r) of the Social Security

1 Act (42 U.S.C. 1395x(r)) is amended to read as follows: “(4)
2 a doctor of optometry, but only with respect to the provision
3 of items or services described in subsection (s) which he is
4 legally authorized to perform as a doctor of optometry by the
5 State in which he performs them,”.

6 (b) REQUIRING PAYMENT FOR CERTAIN SERVICES
7 UNDER PART B TO BE ON THE BASIS OF AN ASSIGN-
8 MENT.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is
9 amended—

10 (1) by striking out “or” at the end of paragraph
11 (13),

12 (2) by striking out the period at the end of para-
13 graph (14) and inserting in lieu thereof “; or”, and

14 (3) by adding at the end the following new
15 paragraph:

16 “(15) which a doctor of optometry is authorized
17 under State law to furnish as such a doctor (whether
18 or not the services were furnished by a doctor of op-
19 tometry, an ophthalmologist, or other physician), unless
20 (in the case of payment under part B) payment is made
21 on the basis of an assignment under section
22 1842(b)(3)(B)(ii), in accordance with section
23 1842(b)(6)(B), or under the procedure described in sec-
24 tion 1870(f)(1).”.

1 (c) DETERMINATION OF REASONABLE CHARGE.—Sec-
2 tion 1842(b) of such Act (42 U.S.C. 1395u(b)) is amended by
3 adding at the end the following new paragraph:

4 “(8) In determining prevailing charge levels for physi-
5 cians’ services under paragraph (3), customary charges made
6 by physicians described in section 1861(r)(4) shall be includ-
7 ed, whether or not such services are or were reimbursable.”.

8 (d) EFFECTIVE DATES.—(1) The amendments made by
9 subsections (a) and (b) of this section shall apply to services
10 furnished on or after April 1, 1986.

11 (2) The amendment made by subsection (c) of this sec-
12 tion shall apply to the determination of reasonable charges
13 for fee-screen years beginning on or after October 1, 1985.

99TH CONGRESS
1ST SESSION

H. R. 2807

To amend titles XVIII and XIX of the Social Security Act to require second opinions with respect to certain surgical procedures as a condition of payment under the Medicare and Medicaid Programs.

IN THE HOUSE OF REPRESENTATIVES

JUNE 19, 1985

Mrs. KENNELLY introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

A BILL

To amend titles XVIII and XIX of the Social Security Act to require second opinions with respect to certain surgical procedures as a condition of payment under the Medicare and Medicaid Programs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SHORT TITLE

4 SECTION 1. This Act may be cited as the "Medicare
5 and Medicaid Second Opinion Act of 1985".

6 MEDICARE REQUIREMENTS

7 SEC. 2. (a) IN GENERAL.—Title XVIII of the Social
8 Security Act is amended by adding at the end thereof the
9 following new section:

1 "SECOND OPINIONS FOR CERTAIN SURGICAL PROCEDURES

2 "SEC. 1890. (a) CONDITION OF PAYMENT.—No pay-
3 ment shall be made under part A or part B with respect to
4 items or services furnished in connection with a surgical pro-
5 cedure listed by the Secretary pursuant to this section unless
6 the individual undergoing the procedure (or such individual's
7 representative) obtains a second opinion as to the necessity
8 and appropriateness of such procedure, in accordance with
9 this section. For purposes of determining whether an opinion
10 is the second opinion, the first opinion must be made by a
11 physician who is qualified to perform the surgical procedure,
12 and the second opinion is any subsequent opinion made by a
13 physician of the appropriate speciality, as determined under
14 subsection (b)(3). Such second opinion need not necessarily
15 agree with the first opinion in order for payment to be made.

16 "(b) SURGICAL PROCEDURES TO WHICH CONDITION
17 APPLIES.—

18 "(1) SECRETARY TO ESTABLISH LIST.—The Sec-
19 retary shall establish a list of not less than 10 surgical
20 procedures to which the requirements of this section
21 shall apply. The Secretary shall establish such list
22 based upon the following criteria:

23 "(A) The procedure is one which generally
24 can be postponed without undue risk to the pa-
25 tient.

1 “(B) The procedure is a high volume proce-
2 dure among patients who are covered under the
3 programs established under this title, or is a high
4 cost procedure.

5 “(C) The procedure has a high rate of non-
6 confirmation upon requesting a second opinion,
7 based upon data available to the Secretary from
8 any sources.

9 “(2) LIST VARIATIONS.—The Secretary may vary
10 the list on a State-by-State basis, or within areas of a
11 State, if data available with regard to volume and costs
12 of procedures suggest that to do so would be cost ef-
13 fective and would better serve the purposes of this sec-
14 tion.

15 “(3) LIST TO SPECIFY SPECIALISTS WHO MUST
16 RENDER SECOND OPINION.—The Secretary shall
17 specify, for each procedure on a list established under
18 this subsection, the type or types of board certified or
19 board eligible specialists who must be consulted for the
20 second opinion, based upon the nature of the proce-
21 dure.

22 “(c) REFERRAL MECHANISM FOR SECOND OPIN-
23 IONS.—

24 “(1) USE OF PRO AS REFERRAL CENTER.—The
25 Secretary shall enter into or modify contracts with uti-

1 lization and quality control peer review organizations
2 under which such organizations shall serve as referral
3 centers for second opinions required under this section.
4 Each such organization shall, if the patient seeking the
5 second opinion so requests, obtain the relevant medical
6 records from the physician who rendered the first opin-
7 ion that the procedure was necessary, and provide the
8 relevant information to the physician selected by the
9 patient to render the second opinion in such form so as
10 not to identify the physician who rendered the first
11 opinion.

12 “(2) REFERRAL OF PATIENT.—If the patient
13 seeking the second opinion so requests, the organiza-
14 tion shall refer such patient to a physician of the ap-
15 propriate specialty for purposes of providing the second
16 opinion. The organization shall only make such refer-
17 rals to physicians who are participating physicians or
18 who agree to accept assignment for all such referrals.

19 “(3) FREEDOM OF CHOICE OF PATIENT TO
20 CHOOSE PHYSICIAN.—Subject to paragraph (4), the
21 patient may choose any physician of the proper special-
22 ty to provide the second opinion.

23 “(4) PHYSICIANS PROHIBITED FROM PROVIDING
24 SECOND OPINION.—For purposes of this section, a
25 second opinion may not be provided by a physician

1 who is affiliated with, or has any direct or indirect
2 common financial interest with, the physician who ren-
3 dered the first opinion that the procedure was neces-
4 sary.

5 “(5) USE OF OTHER ENTITIES AS REFERRAL
6 CENTERS.—(A) If no utilization and quality control
7 peer review organization is available to perform the
8 functions described in this subsection, the Secretary
9 may enter into an agreement with a State or local
10 agency or appropriate private entity to perform such
11 functions.

12 “(B) If a State is utilizing an entity other than a
13 utilization and quality control peer review organization
14 to provide referrals pursuant to section 1919, the Sec-
15 retary may enter into an agreement under this section
16 with such entity to perform the functions described in
17 this section (rather than with a utilization and quality
18 control peer review organization) if the Secretary de-
19 termines that such arrangement would be more cost ef-
20 fective and would adequately protect the patients re-
21 ceiving benefits under this title.

22 “(d) EXCEPTIONS TO REQUIREMENT.—The require-
23 ments of this section shall not apply—

24 “(1) if delay in providing the surgical procedure
25 would be a risk to the patient;

1 “(2) if no physician is available (within such rea-
2 sonable limits as the Secretary shall determine by reg-
3 ulation) who is (A) an appropriate specialist, and (B) a
4 participating physician or a physician who has agreed
5 to accept assignment for the second opinion; or

6 “(3) the surgical procedure is to be performed on
7 a patient who is a member of a health maintenance or-
8 ganization or competitive medical plan having a risk-
9 sharing contract with the Secretary under section
10 1876(g).

11 “(e) DUTIES OF PHYSICIANS, HOSPITALS, AND AMBU-
12 LATORY SURGICAL CENTERS TO NOTIFY PATIENTS.—

13 “(1) NOTICE.—Any physician, hospital, or ambu-
14 latory surgical center shall, prior to furnishing services
15 in connection with a surgical procedure which requires
16 a second opinion pursuant to this section, inform the
17 patient of the necessity of obtaining a second opinion,
18 and make available to the patient, or to the entity per-
19 forming a referral under subsection (c) if so requested
20 by the patient, any medical records necessary in order
21 for the patient to obtain such second opinion.

22 “(2) SANCTIONS.—(A) In the case of any physi-
23 cian, hospital, or ambulatory surgical center which fails
24 to notify a patient of the need to obtain a second opin-

ion or fails to make available medical records, as required under paragraph (1), the Secretary may—

“(i) impose a civil monetary penalty and assessment, in the same manner as such penalties are authorized under section 1128A(a), or

“(ii) in the case of a second or subsequent failure, bar the physician, hospital, or ambulatory surgical center from participation under the program under this title for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1862(d),

or both. No payment may be made under this title with respect to any item or service furnished by a physician, hospital, or ambulatory surgical center during the period when it is barred from participation in the program under this title pursuant to this subsection.

“(B) The Secretary may not bar a physician, hospital, or ambulatory surgical center pursuant to subparagraph (A) if such physician, hospital, or ambulatory surgical center is a sole source of essential services in a community.

“(C) The Secretary shall take into account access of beneficiaries to physicians’ services and hospital services for which payment may be made under this title in determining whether to bar a physician, hospi-

1 tal, or ambulatory surgical center from participation
2 pursuant to subparagraph (A).

3 “(D) In any case where payment under this title
4 is denied by reason of this section, and a physician,
5 hospital, or ambulatory surgical center failed to notify
6 the patient as required by paragraph (1), the Secretary
7 may, out of any civil monetary penalty or assessment
8 collected from such physician, hospital, or ambulatory
9 surgical center pursuant to this subsection, make a
10 payment to the patient in the nature of restitution for
11 amounts paid by such patient to such physician, hospi-
12 tal, or ambulatory surgical center which otherwise
13 would have been paid under this title.

14 “(f) NOTICE BY SECRETARY.—

15 “(1) NOTICE TO PHYSICIANS, HOSPITALS, AND
16 AMBULATORY SURGICAL CENTERS.—The Secretary
17 shall notify all participating physicians, all hospitals
18 having agreements under section 1866, all ambulatory
19 surgical centers having an agreement with the Secre-
20 tary described in section 1832(a)(2)(F), and to the
21 extent feasible all other physicians, either directly or
22 through carriers with whom the Secretary has a con-
23 tract under section 1842, of the requirements of this
24 section. The notice shall include the applicable list of
25 surgical procedures to which such requirements apply,

1 and a description of the penalties for failure to notify a
2 patient concerning such requirements.

3 “(2) PUBLIC NOTICE.—The Secretary shall pro-
4 vide for periodic public notice to all beneficiaries under
5 this title of the requirements of this section, including
6 the applicable list of the surgical procedures to which
7 such requirements apply. The Secretary shall make the
8 applicable lists available at district and branch offices
9 of the Social Security Administration, in the offices of
10 carriers, and to senior citizen organizations.”.

11 (b) WAIVER OF DEDUCTIBLE AND COPAYMENTS.—

12 (1) DEDUCTIBLE.—Section 1833(b) of the Social
13 Security Act is amended by striking out “and” before
14 “(4)”, and by inserting before the period at the end of
15 the first sentence the following: “, and (5) such deduct-
16 ible shall not apply with respect to items and services
17 furnished in connection with obtaining a second opinion
18 required under section 1890 (or a third opinion, if such
19 second opinion was in disagreement with the first
20 opinion)”.

21 (2) COPAYMENTS.—(A) Section 1833(a)(1) of
22 such Act is amended by striking out “and” before
23 “(F)”, and by inserting before the semicolon at the end
24 thereof the following: “, and (G) with respect to items
25 and services furnished in connection with obtaining a

1 second opinion required under section 1890 (or a third
2 opinion, if such second opinion was in disagreement
3 with the first opinion), the amounts paid shall be 100
4 percent of the reasonable charges for such items and
5 services”.

6 (B) Section 1833(a)(2)(A) of such Act is amended
7 by inserting “, items and services furnished in connec-
8 tion with obtaining a second opinion required under
9 section 1890 (or a third opinion, if such second opinion
10 was in disagreement with the first opinion),” after
11 “(other than durable medical equipment)”.

12 (C) Section 1833(a)(2)(D) of such Act is amended
13 by striking out “or to a provider having an agreement
14 under section 1866” and inserting in lieu thereof “to a
15 provider having an agreement under section 1866, or
16 for tests furnished in connection with obtaining a
17 second opinion required under section 1890 (or a third
18 opinion, if such second opinion was in disagreement
19 with the first opinion)”.

20 (c) CONFORMING AMENDMENTS.—

21 (1) EXCLUSIONS FROM COVERAGE.—Section
22 1862(a) of the Social Security Act is amended—

23 (A) by striking out “or” at the end of para-
24 graph (13);

1 (B) by striking out the period at the end of
2 paragraph (14) and inserting in lieu thereof “;
3 or”; and

4 (C) by adding at the end thereof the follow-
5 ing new paragraph:

6 “(15) furnished in connection with a surgical pro-
7 cedure if a second opinion is required under section
8 1890 but is not obtained.”.

9 (2) PROVIDER AGREEMENTS.—Section 1866(a)(1)
10 of such Act is amended—

11 (A) by striking out “and” at the end of sub-
12 paragraph (G);

13 (B) by striking out the period at the end of
14 subparagraph (H) and inserting in lieu thereof “,
15 and”; and

16 (C) by inserting after subparagraph (H) the
17 following new subparagraph:

18 “(I) to notify beneficiaries under this title for
19 whom surgery is to be performed of the need to obtain
20 a second opinion if such surgery is a procedure listed
21 pursuant to section 1890.”.

22 (3) PARTICIPATING PHYSICIANS.—Section
23 1842(h)(1) of such Act is amended by inserting before
24 the period at the end of the second sentence the fol-
25 lowing: “, and that such physician will notify any ben-

1 eficiary under this title for whom surgery is to be per-
2 formed of the need to obtain a second opinion if such
3 surgery is a procedure listed pursuant to section
4 1890”.

5 (4) FUNCTIONS OF PEER REVIEW ORGANIZA-
6 TIONS.—Section 1154(a) of such Act is amended by
7 adding at the end thereof the following new paragraph:

8 “(12) The organization shall perform any referral
9 functions for second opinions requested by the Secre-
10 tary pursuant to section 1890(c).”.

11 MEDICAID REQUIREMENTS

12 SEC. 3. (a) STATE PLAN REQUIREMENT.—Section
13 1902(a) of the Social Security Act is amended—

14 (1) by striking out “and” at the end of paragraph
15 (45);

16 (2) by striking out the period at the end of para-
17 graph (46) and inserting in lieu thereof “; and”; and

18 (3) by inserting after paragraph (46) the following
19 new paragraph:

20 “(47) provide that second opinions shall be re-
21 quired for payment for certain surgical procedures in
22 accordance with section 1919.”.

23 (b) REQUIREMENT OF SECOND OPINION.—Title XIX
24 of the Social Security Act is amended by adding at the end
25 thereof the following new section:

1 "SECOND OPINIONS FOR CERTAIN SURGICAL PROCEDURES

2 "SEC. 1919. (a) IN GENERAL.—The State plan must
3 contain requirements that second opinions be obtained before
4 payment will be made under the plan for surgical procedures
5 which are listed by the Secretary for such State (or for an
6 area within the State) under section 1890.

7 "(b) MEDICARE REQUIREMENTS TO APPLY.—

8 "(1) IN GENERAL.—Except as otherwise provided
9 in this section, the provisions of section 1890 as they
10 apply to payment made for surgical procedures under
11 title XVIII shall also apply to the requirement im-
12 posed by this section.

13 "(2) STATE MAY MODIFY LIST.—The State may,
14 if approved by the Secretary, modify the list of surgical
15 procedures applicable to such State (or an area within
16 the State) if data indicates that the modification is cost
17 effective, based upon the volume, cost, or rate of non-
18 confirmation of the procedure to be added or deleted
19 from the list with respect to the population served by
20 the State plan. No procedure may be added to the list
21 unless the procedure is one which generally can be
22 postponed without undue risk to the patient.

23 "(3) REFERRAL.—The State may enter into an
24 agreement with a utilization and quality control peer
25 review organization, in the same manner as the Secre-

tary does so pursuant to section 1890(c), to provide the referral functions required by such section, or the State may utilize a State or local agency or a private entity to perform such functions.

“(4) NOTIFICATION AND ENFORCEMENT.—The State shall establish a mechanism for notifying physicians, hospitals, and ambulatory surgical centers of their duty to inform patients of the requirements of this section, and shall establish a method of enforcement of such requirement through the use of penalties, each of which is substantially equivalent to the notification and enforcement mechanisms applicable under section 1890.

“(c) COST SHARING NOT TO APPLY.—If the State plan requires any deduction, cost sharing, or similar charge for any individual, such requirement shall not apply to items and services furnished in connection with obtaining a second opinion required under this section (or a third opinion, if such second opinion was in disagreement with the first opinion).”.

EFFECTIVE DATES

SEC. 4. (a) MEDICARE AMENDMENTS.—The amendments made by section 2 shall apply to items and services furnished on or after the first day of the first month which begins more than 6 months after the date of the enactment of this Act.

(b) MEDICAID AMENDMENTS.—

1 (1) IN GENERAL.—Except as provided in para-
2 graph (2), the amendments made by section 3 shall
3 apply to items and services furnished in calendar quar-
4 ters beginning more than 6 months after the date of
5 the enactment of this Act.

6 (2) DELAY WHERE STATE LEGISLATION IS RE-
7 QUIRED.—In the case of a State plan for medical as-
8 sistance under title XIX of the Social Security Act
9 which the Secretary of Health and Human Services
10 determines requires State legislation in order for the
11 plan to meet the additional requirements imposed by
12 the amendments made by section 3, the State plan
13 shall not be regarded as failing to comply with the re-
14 quirements of such title solely on the basis of its failure
15 to meet these additional requirements before the first
16 day of the first calendar quarter beginning more than 6
17 months after the date of the enactment of this Act, and
18 after the close of the first regular session of the State
19 legislature that begins after the date of the enactment
20 of this Act.

21 (c) REGULATIONS.—The Secretary of Health and
22 Human Services shall promulgate final regulations necessary
23 to implement the amendments made by this Act within 6
24 months after the date of the enactment of this Act.

1 (d) INTERIM LIST.—(1) If the Secretary of Health and
2 Human Services has not established a list or lists of surgical
3 procedures requiring second opinions, as required under sec-
4 tion 1890 of the Social Security Act, within 6 months after
5 the date of the enactment of this Act, then the following list
6 shall be in effect for purposes of such section:

- 7 Coronary artery bypass.
- 8 Cardiac pacemaker implantation.
- 9 Cataract surgery.
- 10 Gall bladder surgery.
- 11 Prostate surgery.
- 12 Knee surgery.
- 13 Hysterectomy.
- 14 Back surgery.
- 15 Hernia repair.
- 16 Hemorrhoidectomy.

17 (2) The list in paragraph (1) shall remain in effect until
18 such time as the Secretary establishes a new list for the ap-
19 plicable State or area pursuant to section 1890.

20 STUDY

21 SEC. 5. The Secretary of Health and Human Services
22 shall conduct a study of the results of the amendments made
23 by this Act. Such study shall include any changes in utiliza-
24 tion of surgical procedures, changes in nonconfirmation rates
25 of second opinions, and outcomes in cases where surgery is
26 not done after a second opinion failed to confirm the necessity

1 of the surgical procedure. The Secretary shall report the re-
2 sults of the study to the Congress within 24 months after the
3 date of the enactment of this Act.

99TH CONGRESS
1ST SESSION

H. R. 2703

To amend titles XVIII and XIX of the Social Security Act to provide for coverage of respiratory care services for ventilator-dependent individuals under medicare and medicaid.

IN THE HOUSE OF REPRESENTATIVES

JUNE 6, 1985

Mr. WYDEN (for himself, Mr. FLORIO, Mr. BRYANT, and Mr. FORD of Tennessee) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

A BILL

To amend titles XVIII and XIX of the Social Security Act to provide for coverage of respiratory care services for ventilator-dependent individuals under medicare and medicaid.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Home Respiratory Care
5 Act of 1985".

6 **SEC. 2. COVERAGE OF RESPIRATORY CARE SERVICES FOR**
7 **VENTILATOR-DEPENDENT INDIVIDUALS.**

8 (a) **UNDER MEDICARE PROGRAM.—**

1 (1) AS PART OF HOME HEALTH SERVICES.—(A)
2 Section 1861(m)(2) of the Social Security Act (42
3 U.S.C. 1395x(m)(2)) is amended by inserting before the
4 semicolon at the end the following: “, or respiratory
5 care for a qualified respiratory care patient (as defined
6 in subsection (ee))”.

7 (B) Sections 1814(a)(2)(C) and 1835(a)(2)(A) of
8 such Act (42 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)) are
9 amended by inserting after “speech therapy” the fol-
10 lowing: “, or, in the case of a qualified respiratory care
11 patient (as defined in section 1861(ee)), respiratory
12 care,”.

13 (2) AS PART OF EXTENDED CARE SERVICES.—

14 (A) Section 1861(h)(3) of such Act (42 U.S.C.
15 1395x(h)(3)) is amended by inserting after “speech
16 therapy” the following: “, or respiratory care for a
17 qualified respiratory care patient (as defined in subsec-
18 tion (ee)),”.

19 (B) Section 1814(a)(2)(B) of such Act (42 U.S.C.
20 1395f(a)(2)(B)) is amended by inserting after “rehabili-
21 tation services,” the following: “or, in the case of a
22 qualified respiratory care patient (as defined in section
23 1861(ee)), respiratory care,”.

24 (C) Section 1813(a)(3) of such Act (42 U.S.C.
25 1395e(a)(3)) is amended by inserting after “one-eighth”

1 the following: “(or one-sixteenth in the case of a quali-
2 fied respiratory care patient, as defined in section
3 1861(ee))”.

4 (3) DEFINITION OF QUALIFIED RESPIRATORY
5 CARE PATIENT.—Section 1861 of such Act (42 U.S.C.
6 1395x) is amended by adding at the end the following
7 new subsection:

8 “Qualified Respiratory Care Patient

9 “(ee) The term ‘qualified respiratory care patient’
10 means—

11 “(1) with respect to respiratory care furnished as
12 part of extended care services during a spell of illness,
13 an individual who—

14 “(A) is medically dependent on a ventilator
15 for life support at least six hours per day,

16 “(B) before admission to the skilled nursing
17 facility, was so dependent (for life support at least
18 six hours per day) as part of inpatient hospital
19 services for at least 30 consecutive days during
20 the spell of illness,

21 “(C) but for the provision of respiratory care
22 as part of the extended care services, would re-
23 quire respiratory care as part of inpatient hospital
24 services,

1 “(D) has adequate social support services to
2 be cared for at home, and

3 “(E) wishes to be cared for at home; and

4 “(2) with respect to respiratory care furnished as
5 part of home health services during or following a spell
6 of illness, an individual—

7 “(A) is medically dependent on a ventilator
8 for life support at least six hours per day,

9 “(B) before first being furnished home health
10 services during the spell of illness, was so depend-
11 ent (for life support at least six hours per day) as
12 part of inpatient hospital services or post-hospital
13 extended care services for at least 30 consecutive
14 days during the spell of illness, and

15 “(C) but for the provision of respiratory care
16 as part of the home health services, would require
17 respiratory care as part of inpatient hospital serv-
18 ices or extended care services.”.

19 (b) UNDER MEDICAID PROGRAM.—Section 1902(a)(10)
20 of such Act (42 U.S.C. 1396a(a)(10)) is amended by striking
21 out “and” at the end of subparagraph (C), by adding “and”
22 at the end of subparagraph (D), and by inserting after sub-
23 paragraph (D) the following new subparagraph:

24 “(E) for the inclusion of home respiratory
25 care for any individual who—

1 “(i) is medically dependent on a ventila-
2 tor for life support at least six hours per day,

3 “(ii) has been so dependent for at least
4 30 consecutive days or the maximum number
5 of days authorized under the State plan,
6 whichever is less, as an inpatient in one or
7 more hospitals, skilled nursing facilities, or
8 intermediate care facilities,

9 “(iii) but for the inclusion of home respi-
10 ratory care, would require respiratory care
11 as an inpatient in a hospital, skilled nursing
12 facility, or intermediate care facility,

13 “(iv) has adequate social support serv-
14 ices to be cared for at home, and

15 “(v) wishes to be cared for at home;”.

16 (c) EFFECTIVE DATES.—

17 (1) MEDICARE AMENDMENTS.—The amendments
18 made by subsection (a) shall apply to services per-
19 formed on or after the first day of the first month be-
20 ginning 60 days after the date of the enactment of this
21 Act.

22 (2) MEDICAID AMENDMENTS.—(A) Except as
23 provided in subparagraph (B), the amendments made
24 by subsection (b) shall apply to services performed on
25 or after the first day of the first calendar quarter begin-

6

1 ning 60 days after the date of the enactment of this
2 Act.

3 (B) In the case of a State plan for medical assist-
4 ance under title XIX of the Social Security Act that
5 the Secretary of Health and Human Services deter-
6 mines requires State legislation in order for the plan to
7 meet the additional requirement imposed by the
8 amendments made by subsection (b), the State plan
9 shall not be regarded as failing to comply with the re-
10 quirements of such title solely on the basis of its failure
11 to meet that additional requirement before the first day
12 of the first calendar quarter beginning after the close of
13 the first regular session of the State legislature that
14 begins after the date of the enactment of this Act.

Mr. WAXMAN. Before I call upon our witnesses, I would like to recognize Mr. Whittaker.

Mr. WHITTAKER. I have no comment.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Thank you very much, Mr. Chairman.

I think just the size of today's attendance indicates the dramatic public interest in this issue. I have just a couple of comments as we begin this important hearing. When Congress established a prospective payment system for Medicare hospital reimbursement, it put in place the most revolutionary changes in Federal health policy since Medicare began in 1965.

I think we all know that the new system was much needed because the old system, based on costs, rewarded the grossly inefficient. In addition, the Congressional Budget Office told us if we stayed with the old system, we essentially would have run out of money.

But the new Medicare system has brought new problems, problems, in my view, that affect the entire Medicare Program. For example, in recent months we have received a great deal of information that indicates that senior citizens, patients, are pushed out of hospitals too early and, in effect, are not getting the care they need.

We are also getting new information that indicates that in some areas the quality of health care has suffered in other ways under the new system.

Finally, we are also hearing concerns about the arbitrariness of the new system under the old appeals and the claims procedures. I think this issue of fairness has always been important, but it is even more so now under the part B of the Medicare Program because the changes that we have made in recent years have put even more emphasis on outpatient care, the part of the program that is covered by part B.

So today we are opening these hearings to look at how to try to address these problems and do them within some very strong stipulations from our budget committees to produce only savings proposals, not expenditures.

Like you, Mr. Chairman, I do not think there are any grand solutions. I do not think there are any simple kinds of approaches. I think there are a number of steps that we ought to take, and there are just two that I would like to mention very quickly in which I have a great interest.

One of them deals with the Medicare appeals process and the question of making the program operate more fairly. I have introduced legislation that would ensure that senior citizens would have a right to work with their health care providers in an appeals proceeding, and would also have the same appeals rights under the part B of the program, the program that has gotten so much more important, as they do under part A.

The second piece of legislation that I am very interested in hearing our witnesses talk about today deals with long-term care, and particularly the question of helping the private sector get into the area of long-term care insurance to relieve some of the burden on Medicare and Medicaid.

My interest in this area stems from the fact that clearly, with scarce resources, we have to target our resources, at least in Government, on those older people most in need. And I think if we can get the private sector involved in this issue, that will help us target our resources at the Government level to those who need them the most directly.

In recent days I have had a number of meetings with the National Association of Insurance Commissioners. I have introduced legislation. They have made a number of good recommendations.

Senator Durenberger has introduced a companion bill on the Senate side as well. I am very hopeful that our witnesses can give us practical suggestions today as to how to get the private sector into the field of long-term care and to do it in such a way as to strengthen the Medicaid Program, in particular, so it can focus on the needs of the low-income elderly.

Thank you, Mr. Chairman.

Mr. WAXMAN. We are pleased to call for our first witness our colleague the Honorable Barbara B. Kennelly, who has some thoughts for us as to how we can achieve at least some of our objectives.

Ms. Kennelly, we have a vote, a quorum first, and then a vote. I am prepared to skip the quorum, if necessary.

Ms. KENNELLY. I haven't skipped in a long time. Let's go. Whatever you want, Mr. Chairman.

Mr. WAXMAN. What I want is what you want.

Ms. KENNELLY. If you skip, I will skip, and I will read fast.

Mr. WYDEN. It's a meeting of the minds of ways and means and commerce.

STATEMENT OF HON. BARBARA B. KENNELLY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mrs. KENNELLY. Thank you for letting me appear before you, and let me commend you for holding this hearing. I am here today to speak to you about H.R. 2807, the Medicare-Medicaid Second Opinion Act of 1985. H.R. 2807 would address two important issues. First, it would help hold down the soaring costs of Medicare, an important goal when physicians' reimbursement under part B will cost the Federal Treasury \$23 billion. By helping to control Medicare and Medicaid costs, H.R. 2807 can make an important contribution to our efforts to reduce the Federal budget deficit.

As you know, the Congressional Budget Office has estimated that a fully implemented second surgical opinion program will save \$100 million in 1986, \$20 million of that in Medicaid and the remaining \$80 million in Medicare. The inspector general of the Department of Health and Human Services, who will testify later, cites the 1982-83 study estimating savings of \$60 million annually in Medicaid and \$95 million for Medicare. Yet the key test, as you know so well, for health legislation is not whether it saves money, but whether it protects health.

H.R. 2807 more than meets this test by requiring second surgical opinions. This bill will help consumers of health care make informed decisions and could potentially reduce unnecessary surgery for Medicare and Medicaid patients. Many of us will face the prospect of surgery at some time in our lives. In most cases, surgery

will improve our quality of life. In some cases, it will save our lives. In a few instances, surgery can be an unnecessary, even life-threatening situation.

It is unfortunate but true that for many common medical conditions, there is no consensus among health practitioners about appropriate or necessary treatment. Elective surgery can be recommended for good reasons—scientific consensus or a reasoned judgment as to relative risks and benefits; or for bad reasons—an individual physician's idiosyncrasies, insecurity, or inexperience; professional or patient convenience; or the perceived need to practice defensive medicine.

As a result, medical services for a given condition vary widely from place to place. For example, the probability that a woman will undergo a hysterectomy before age 75 varies from less than 15 percent to well over 60 percent depending on her place of residence. Similarly, a man's chances of a prostate removal range from 15 to 50 percent, again depending on where he lives.

Clearly, unnecessary surgery is performed in the United States. To reduce it and the risks associated with unneeded surgery, this bill would require Medicare and Medicaid beneficiaries to obtain a second opinion before undergoing certain common elective surgical procedures. The bill provides for waivers in cases where delay might be a risk to the patient.

Mr. Chairman, the private sector has dramatically increased its use of mandatory surgical second opinion programs in the last few years. According to a recent survey, 58 percent of employers now have programs of this kind, and two-thirds of all Blue Cross plans, including the Blue Cross organization in my home State of Connecticut, now require second opinions before elective surgery.

As a result, rates of surgery have fallen as much as 60 percent, and insurers have achieved savings of up to \$8 for every dollar spent.

There is significant public support for programs of this kind. The recent Equitable health care survey reveals that 68 percent of the respondents felt that the second opinion program was acceptable. They generally saw second opinion as an additional benefit not as a limitation on benefits. It seems they believe, as I do, that a second opinion can help to avoid unnecessary and costly surgery.

Mr. Chairman, I am pleased to be here. I could go on, but I won't. I will say that following you and watching your work, I know you understand what we are talking about. This is not only a good piece of legislation, but it is something that has to be done. We are very aware, Mr. Chairman, that older people respect their doctors. Sometimes their doctor is the only person they have to rely on. As a result, unless something like this is done, Mr. Chairman, they are not going to ask for that second opinion.

So I think this bill would ensure that Americans receive the health care they need and deserve, while at the same time reducing or eliminating unnecessary surgery and the high costs that go with it.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mrs. Kennelly.

It makes good sense on policy to require a second opinion, even if we are not able to show large cost savings. It is being done in the

private sector for the simple reason that they hope it will save money, but, too, it is just good, sound judgment to not rush into surgery, elective surgery where a second opinion can confirm whether that surgery is the wisest course for that patient to take.

I commend you for your proposal. I think you gave an excellent statement. If we had another member here, we would get a second opinion on that.

Mrs. KENNELLY. Thank you, sir.

Mr. WAXMAN. Let's take a short recess, and we will be back in 10 minutes to convene the hearing again.

[Brief recess.]

Ms. MIKULSKI [presiding]. The committee will come to order. Mr. Waxman will be returning shortly from the floor, but in the interests of time and budget reconciliation, we would like now to call upon Dr. Carolyn Davis, Administrator of the Health Care Finance Agency, for her comments.

The committee welcomes you, Dr. Davis, and looks forward to those comments.

**STATEMENT OF CAROLYNE K. DAVIS, PH.D., ADMINISTRATOR,
HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF
HEALTH AND HUMAN SERVICES, ACCOMPANIED BY CHARLES
BOOTH, DIRECTOR, OFFICE OF REIMBURSEMENT POLICY**

Ms. DAVIS. Last year in the Deficit Reduction Act, Congress enacted significant reforms in the Supplemental Insurance Program that helped to reduce the rate of increase in the part B outlays. The fiscal year 1986 budget builds on the progress we made, and it is part of the Governmentwide effort to reduce the Federal budget deficit.

Enactment should produce savings of \$5 billion over the 3-year period beginning fiscal year 1986. In previous testimony in front of this committee I testified on physician services, and I reported on the implementation of both the participating physician program, and the freeze in the actual charges. Since that time, it is important to note that the assignment rates have continued to increase. In fact, for the January through March quarter, 66.8 percent of the dollars were paid under assignment. That represents about a 2.9-percent increase over the previous quarter.

In the month of May, the claims assignment rate was 69.3 percent of all claims being processed. The assignment rate increase has been across the board. For example, in the January through March quarter the assignment rates increased in all of the carriers over the previous year.

More than one-half of the carriers had an increase of 20 percent or greater, and indeed, 4 of the carriers had increases that were more than 50 percent. Virtually all of the nonparticipating physicians continued to comply with the freeze on the actual charges, and 99 percent of all the cases where warning letters have been sent have been resolved satisfactorily.

We believe that, taken together, the participating physicians program, the freeze, and the other changes mandated by DEFRA have increased the financial protection provided under the part B program.

In the interest of time I will very quickly highlight several of the proposals in the fiscal year 1986 budget. The physicians fee freeze is a proposal for extending the fee freeze for another year, and in the context of the earlier Senate-White House agreement on the budget resolution, the budget proposal was modified so that participating physicians would have both the customary and prevailing charges upgraded, while nonparticipating physicians would continue to have their fees frozen.

The fee extension freeze would maintain and strengthen Medicare reimbursement until our longer range reforms are ready to be put in place. In the laboratory fee freeze area, current laboratory fee schedules established by the Deficit Reduction Act would be maintained for another year. Future increases would not recognize a catch up factor.

In addition, the Secretary would be granted the authority to continue to reimburse the lab services to the outpatients on the basis of a schedule rather than reverting to cost reimbursement as of July 1, 1987. This proposal, also is part of our across-the-board effort to freeze reimbursements. We think this freeze is justified and is supported by the inspector general's report. Initially, when we were considering what reduction to set and what kind of a markup there was, we indicated that the belief was that there were excessive markups that were associated with lab services and the recommendations were to reimburse under what the current schedules provide. So we believe the current schedules are generous enough to be maintained for another year.

We are also recommending maintaining the charge levels for the durable medical equipment [DME] and the other part B services. The reasonable charges for DME prosthetic devices, ambulance services, and other nonphysician services would be maintained for one year. Thereafter, the reasonable charges would be limited to the changes in the CPI in order to bring our reimbursements in these areas more under control.

We have a working proposal, a simple extension of eliminating the current age limit on workers and spouses subjected to the Medicare secondary payor provision and including those that are workers and spouses that are over the age of 70. Currently, only the under 70 are included.

We have recommended an increase in the premiums paid under part B from the current 25 percent of the aged program costs to 35 percent by 1990, escalating approximately two percent a year.

As you know, under the current law, beginning 1988, the part B premium is no longer tied to program growth, and as a result it could cover less than 21 percent of the aged program costs. Given that the initial premiums covered 50 percent of the cost, we think that this is a reasonable financing reform.

We are proposing also to index the part B deductible after a 1-year freeze. The part B deductible would be indexed to an annual change in the Medicare economic index. Current law does not provide for the deductible to keep pace with program growth either, and as a result of beneficiary liability, it is a percentage of the program growth, decreasing over time in real terms.

We are also indicating that the first full month of entitlement in Medicare, which begins on the first day of the month—should

begin on the first day of the month following the beneficiary's date of turning age 65. We believe that would achieve significant program savings without imposing a hardship on the beneficiaries.

So, in conclusion, I simply would highlight that the cumulative impact of these proposals would continue to control the rate of increase in the part B expenditures. Even with these proposed changes, our part B outlays will still grow faster than any other domestic program function in the budget. If we take all these proposals together and look at those in the context of proposals affecting part A, the budget reflects the administration's desire to ensure that everyone contributes to the efforts to restrain Medicare growth and to reduce the Federal budget deficit.

That concludes my summary, and I would be happy to answer questions.

[Ms. Davis' prepared statement follows:]

STATEMENT OF
CAROLYNE K. DAVIS, PH.D.
ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION

I AM PLEASED TO BE HERE TODAY TO DISCUSS THE ADMINISTRATION'S FY 1986 BUDGET PROPOSALS AFFECTING MEDICARE PART B.

LAST YEAR, IN THE DEFICIT REDUCTION ACT OF 1984 (DEFRA), CONGRESS ENACTED SIGNIFICANT REFORMS FOR THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM. THESE REFORMS HAVE HELPED TO REDUCE THE RATE OF INCREASE IN PART B OUTLAYS.

OUR FY 1986 BUDGET BUILDS ON THE PROGRESS WE MADE LAST YEAR. IT IS PART OF THE GOVERNMENT-WIDE EFFORT TO REDUCE THE FEDERAL BUDGET DEFICIT. ENACTMENT OF OUR PROPOSALS WOULD PRODUCE FEDERAL SAVINGS OF \$5 BILLION, OVER THE THREE-YEAR PERIOD BEGINNING FY 1986.

BACKGROUND

OVER THE TEN YEAR PERIOD ENDING IN FY 1983, MEDICARE PART B SPENDING INCREASED AT AN ANNUAL RATE OF GROWTH OF CLOSE TO TWENTY PERCENT. DURING THE SAME PERIOD, THE FEDERAL BUDGET AND THE GROSS NATIONAL PRODUCT GREW AT ANNUAL RATES OF 12.3 PERCENT AND 9.6 PERCENT, RESPECTIVELY. IN EVERY YEAR SINCE FY 1975, PART B SPENDING OUTPACED MEDICARE SPENDING FOR PART A.

IN FY 1984, THERE WAS A SIGNIFICANT DECELERATION IN THE RATE OF GROWTH IN MEDICARE PART B PAYMENTS. TO DATE, THIS DECELERATION IS CARRYING OVER INTO THE CURRENT FISCAL YEAR. THE ANNUAL RATE OF INCREASE IN FY 1984 WAS NEARLY HALF THAT OF THE PREVIOUS TEN YEARS.

THIS FY 1984 DECELERATION WAS DUE TO A NUMBER OF FACTORS:

- O THE DROP IN ADMISSIONS FOLLOWING THE IMPLEMENTATION OF PPS, BESIDES REDUCING HOSPITAL EXPENDITURES, ALSO REDUCED EXPENDITURES FOR PHYSICIANS' SERVICES PROVIDED TO HOSPITAL INPATIENTS.
- O SIMILARLY, THE REDUCTION IN HOSPITAL LENGTH OF STAY ALSO PRODUCED PHYSICIANS' SERVICES SAVINGS.
- O THE REDUCTION IN THE RATE OF INCREASE IN MEDICAL INFLATION REDUCED THE PRICE COMPONENT OF FEE INCREASES. THE AMA VOLUNTARY FREEZE MAY HAVE BEEN A CONTRIBUTING FACTOR TO THIS CHANGE.
- O THE FREEZE ON PHYSICIANS' SERVICES AND THE FEE SCHEDULE FOR LAB SERVICES MANDATED BY DEFRA.

DEFICIT REDUCTION ACT OF 1984

OVER THE PAST FOUR YEARS, SIGNIFICANT CHANGES TO THE MEDICARE PROGRAM HAVE BEEN ENACTED IN THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981, THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA), THE SOCIAL SECURITY AMENDMENTS OF 1983 AND DEFRA. A MAJOR FOCUS OF TEFRA AND THE SOCIAL SECURITY AMENDMENTS OF 1983 WAS CONTROLLING THE GROWTH OF MEDICARE PART A SPENDING, PARTICULARLY FOR HOSPITAL SERVICES. UNTIL DEFRA, THESE LEGISLATIVE CHANGES ENACTED BY CONGRESS HAD A RELATIVELY SMALL DIRECT IMPACT ON SERVICES PROVIDED UNDER PART B.

AS A RESULT OF DEFRA, THE FOLLOWING CHANGES WERE MADE TO MEDICARE

PART B

- O A PARTICIPATING PHYSICIAN PROGRAM WAS INITIATED.
- O THE CUSTOMARY AND PREVAILING CHARGES OF PHYSICIANS WERE FROZEN FOR A 15 MONTH PERIOD.
- O THE ACTUAL CHARGES OF NON-PARTICIPATING PHYSICIANS WERE ALSO FROZEN.
- O PHYSICIANS WERE NO LONGER ALLOWED TO BILL FOR LABORATORY SERVICES THAT THEY DID NOT DIRECTLY PROVIDE.
- O FEE SCHEDULES WERE ESTABLISHED FOR LABORATORY SERVICES PROVIDED IN ALL SETTINGS EXCEPT INPATIENT HOSPITAL.

IN PREVIOUS TESTIMONY, I REPORTED ON THE IMPLEMENTATION OF BOTH THE PARTICIPATING PHYSICIAN PROGRAM AND THE FREEZE ON ACTUAL CHARGES OF NON-PARTICIPATING PHYSICIANS. SINCE THAT TIME:

- ASSIGNMENT RATES HAVE CONTINUED TO INCREASE. FOR THE JAN-MAR QUARTER, 66.8 PERCENT OF DOLLARS WERE ACCEPTED ON ASSIGNMENT. THAT IS AN INCREASE OF 2.9 PERCENTAGE POINTS OVER THE PREVIOUS QUARTER. IN THE MONTH OF MAY, THE CLAIMS ASSIGNMENT RATE WAS 69.3 PERCENT.

- THE INCREASE IN ASSIGNMENT RATES IS ACROSS THE BOARD. FOR EXAMPLE, IN THE JAN-MARCH 1985 QUARTER, ASSIGNMENT RATES INCREASED IN ALL CARRIERS OVER THE PREVIOUS YEAR. MORE THAN HALF OF THE CARRIERS HAD AN INCREASE OF 20 PERCENT OR GREATER. FOUR HAD INCREASES OF MORE THAN 50 PERCENT.
- VIRTUALLY ALL NON-PARTICIPATING PHYSICIANS CONTINUE TO COMPLY WITH THE FREEZE ON ACTUAL CHARGES. 99 PERCENT OF ALL CASES WHERE WARNING LETTERS HAD BEEN SENT HAVE BEEN RESOLVED SATISFACTORILY.

THUS, TAKEN TOGETHER, THE PARTICIPATING PHYSICIAN PROGRAM, THE FREEZE AND THE OTHER CHANGES MANDATED BY DEFRA HAVE INCREASED THE FINANCIAL PROTECTION PROVIDED BY THE PART B PROGRAM.

MEDICARE PROPOSALS

LET ME BRIEFLY DESCRIBE OUR PROPOSALS FOR FY 1986.

- 0 PHYSICIAN FEE FREEZE EXTENSION - AS YOU ARE AWARE, THE BUDGET CONTAINED A PROPOSAL TO EXTEND THE PHYSICIAN FEE FREEZE FOR ANOTHER YEAR. IN THE CONTEXT OF THE EARLIER SENATE/WHITE HOUSE AGREEMENT ON THE BUDGET RESOLUTION, THE BUDGET PROPOSAL WAS MODIFIED SO THAT PARTICIPATING PHYSICIANS WOULD HAVE THEIR CUSTOMARY AND PREVAILING CHARGES UPDATED, WHILE NON-PARTICIPATING PHYSICIANS WOULD CONTINUE TO HAVE THEIR FEES FROZEN. THE FREEZE EXTENSION WILL MAINTAIN RESTRAINT ON MEDICARE REIMBURSEMENT UNTIL LONGER

TERM REFORMS ARE READY TO BE PUT IN PLACE. THE THREE YEAR SAVINGS FROM OUR ORIGINAL PROPOSAL ARE \$1.3 BILLION. THE SAVINGS FROM THE SENATE/WHITE HOUSE VERSION ARE \$550 MILLION.

- O LAB FEE FREEZE - THE CURRENT LABORATORY FEE SCHEDULE ESTABLISHED BY DEFRA WOULD BE MAINTAINED FOR ANOTHER YEAR. FUTURE INCREASES WOULD NOT ALLOW FOR A CATCH-UP. IN ADDITION, THE SECRETARY WOULD BE GRANTED THE AUTHORITY TO CONTINUE TO REIMBURSE HOSPITAL LABORATORY SERVICES TO OUTPATIENTS ON THE BASIS OF THE FEE SCHEDULE RATHER THAN REVERTING TO COST REIMBURSEMENT ON JULY 1, 1987. THIS PROPOSAL IS PART OF OUR ACROSS-THE-BOARD EFFORT TO FREEZE REIMBURSEMENT. IT IS ALSO JUSTIFIED BY OUR BELIEF, WHICH IS SUPPORTED BY THE INSPECTOR GENERAL, THAT THE EXCESSIVE MARK-UPS HISTORICALLY ASSOCIATED WITH LABORATORY SERVICES MADE THE CURRENT SCHEDULES GENEROUS. THE THREE YEAR SAVINGS ARE \$80 MILLION.

- O MAINTAIN CHARGES LEVELS FOR DURABLE MEDICAL EQUIPMENT (DME) AND OTHER PART B SERVICES - THE REASONABLE CHARGES FOR DME, PROSTHETIC DEVICES, AMBULANCE SERVICES AND OTHER NON-PHYSICIAN SERVICES WOULD BE MAINTAINED FOR ONE YEAR BEGINNING OCTOBER 1. THEREAFTER, INCREASES IN REASONABLE CHARGES WOULD BE LIMITED TO CHANGES IN THE CPI. OUR PROPOSAL WOULD BEGIN TO BRING SPENDING IN THESE AREAS UNDER CONTROL. THREE YEAR SAVINGS ARE \$300 MILLION.

- 0 WORKING AGED EXTENSION - THIS PROPOSAL WOULD ELIMINATE THE CURRENT AGE LIMIT ON WORKERS AND SPOUSES SUBJECT TO THE MEDICARE SECONDARY PAYOR PROVISIONS BECAUSE OF COVERAGE BY AN EMPLOYER BASED GROUP HEALTH POLICY. UNDER CURRENT LAW THESE PROVISIONS ONLY COVER WORKERS AND SPOUSES UNDER THE AGE 70. THE PART B THREE YEAR SAVINGS ARE \$280 MILLION.
- 0 INCREASE PART B PREMIUM - THE PREMIUMS PAID BY PART B ENROLLEES WOULD BE INCREASED UNDER THIS PROPOSAL FROM THE CURRENT 25 PERCENT OF AGED PROGRAM COSTS TO 35 PERCENT BY 1990. UNDER CURRENT LAW, BEGINNING 1988, THE PART B PREMIUM IS NO LONGER TIED TO PROGRAM GROWTH. AS A RESULT, BY 1990, IT WOULD COVER LESS THAN 21 PERCENT OF AGED PROGRAM COSTS. GIVEN THAT THE PREMIUM COVERED 50 PERCENT OF PROGRAM COSTS AT THE BEGINNING OF THE PROGRAM, THIS PROPOSAL IS A REASONABLE FINANCING REFORM. THE THREE YEAR SAVINGS ARE \$3.2 BILLION.
- 0 INDEX PART B DEDUCTIBLE - AFTER A ONE YEAR FREEZE, THE PART B DEDUCTIBLE WOULD BE INDEXED TO THE ANNUAL CHANGE IN THE MEDICARE ECONOMIC INDEX. CURRENT LAW DOES NOT PROVIDE FOR THE DEDUCTIBLE TO KEEP PACE WITH PROGRAM GROWTH, AS A RESULT BENEFICIARY LIABILITY, AS A PERCENT OF PROGRAM COSTS, WILL DECREASE IN REAL TERMS. THE THREE YEAR SAVINGS ARE \$225 MILLION.
- 0 FIRST FULL MONTH OF ENTITLEMENT TO MEDICARE - ENTITLEMENT TO MEDICARE BENEFITS WOULD BEGIN ON THE FIRST DAY OF THE MONTH

FOLLOWING THE MONTH IN WHICH THE BENEFICIARY TURNS 65. THIS PROPOSAL ACHIEVES SIGNIFICANT PROGRAM SAVINGS WITHOUT IMPOSING MUCH OF A HARDSHIP ON BENEFICIARIES. THE PART B THREE YEAR SAVINGS ARE \$290 MILLION.

CONCLUSION

WE BELIEVE THAT THE CUMULATIVE IMPACT OF THESE PROPOSALS WILL CONTINUE TO CONTROL THE RATE OF INCREASE OF MEDICARE PART B BENEFITS. EVEN WITH THESE PROPOSED CHANGES, PART B OUTLAYS WILL STILL GROW FASTER THAN ANY OTHER DOMESTIC FUNCTION IN THE BUDGET. TAKEN TOGETHER WITH THE PROPOSALS AFFECTING PART A, OUR BUDGET REFLECTS THE ADMINISTRATION'S DESIRE TO ENSURE THAT EVERYONE CONTRIBUTES TO THE EFFORT TO RESTRAIN MEDICARE GROWTH AND TO REDUCE THE FEDERAL BUDGET DEFICIT.

I LOOK FORWARD TO A CONTINUING DIALOGUE WITH THIS COMMITTEE. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS THAT YOU MAY HAVE.

Ms. MIKULSKI. Thank you very much, Dr. Davis.

I have some questions, and also related to those that Chairman Waxman wished to be explored.

The first area are two questions related to physician freezes. The last time you were here, the committee and you discussed the fact of the physicians freezes, and we were interested in what effects the freeze was having on the volume and mix of services and whether there were any significant problems of compliance.

At that time, you said it was just too early to have an informed judgment. Could you now comment on what your experience in that area has been?

Ms. DAVIS. Yes. At that time we did not yet have the second quarter of our data in, and I was a little reluctant to base judgment on one quarter only. But based upon two quarters' worth of evaluation, it does appear to us that there has not been any type of an increase in the volume of services per user.

It is a little early to say just yet. We need a little more analysis, but it begins to look like there may have been a change in the mix of services provided by the nonparticipating physicians. And it also seems like the participating physicians are beginning to increase their market share since the beginning of the participation program.

So although our findings are still preliminary, that is pretty well what we have gleaned so far in relationship to the activities as it relates to the volume and the mix of services. This is based on the data from two quarters we have looked at, and specifically from nine carriers.

Now, over time we will become more comprehensive in that outlook, but it is very reassuring.

Mr. WAXMAN. We have heard some suggestions, and we will hear later testimony today, as a matter of fact, in addition to exempting participating physicians from an extension of the fee freeze, we should also exempt certain services; namely, office visits, nursing home visits, and home visits.

What are your views on that suggestion?

Ms. DAVIS. I am afraid I would be rather reluctant to do that. I believe that to do that: No. 1 would be administratively quite complex; and No. 2, I don't think it gets at quite the concept of rewarding all those who participate and providing incentive for participation. If you start exempting certain categories of services, I would have to question how well the incentive system of the participation program would work. I believe that the freeze is somewhat tied to the participating physician concept.

Mr. WAXMAN. The idea last year was that we put a freeze into effect, and we all agreed we could do that and save some money at the Federal level, and at the same time, since there was a voluntary effort by the doctors to hold down their fees, it would not make that great a difference.

But I certainly do not consider it very desirable to have price controls across the board. And, it is not fair to say that those who participated that they would be allowed to raise their fees, and then not keep that promise.

But if you're going to continue with this freeze because of the budgetary pressure, shouldn't we use this opportunity to redress some of the imbalances between physicians and reimbursements? And one way to do it would be to put the freeze on some but not on others.

Ms. DAVIS. I understand that concept. Clearly, I think we are interested, too, in trying to straighten out the potential inequities in that type of a system. My preference would be to delay that and integrate that into an overall physician reimbursement reform, which we hope will come along by next year. I think I heard you say "exempting office visits," which can be by primary care physicians' services, or they can be from specialists. I am not sure that the simple exemption of office visits would necessarily straighten out inequities that are perceived to be within the value systems themselves.

What you are pointing to is more the necessity for relative value scale studies. And we have been very interested in that. But I would think because of the administrative complexity of teasing that piece out, it would be more important to delay and do that kind of a study.

Mr. WAXMAN. Rather than try to move forward in a health policy notions with this freeze, we are simply going to leave it in effect for budgetary purposes even though it is punitive of doctors, it is price controls on them alone, it disregards the fact that their costs of doing business are going up? We are just going to leave it in there and tell the doctors, "That is too bad. It is not for health policy reasons we are doing this. It is because nobody said life was fair"?

Ms. DAVIS. I think in the proper context we have indicated our overall budget calls for freezes across the board on all of the providers. So this is simply recognition that they are all sharing in that. But within that type of reform, I think it is necessary when you consider physician reform to do it in a very careful studied manner. And I think that the administrative complexity of trying—

Mr. WAXMAN. You consider this reform? Continuing a freeze on physicians a reform of the health care system?

Ms. DAVIS. I think that is a temporary delay while we seek reform. I was addressing the question of whether we should exempt office visits.

Mr. WAXMAN. I understand.

Ms. DAVIS. My suggestion was that to do reform and to do it properly, it would be better to do it across the board in a comprehensive way and that is what we are hoping to do in another year's time.

Mr. WHITTAKER. Dr. Davis, to expand a little bit on what the chairman was inquiring about, because the physician case-by-case assignment rate has increased, do you think it is equitable to continue to penalize the physicians who do not accept assignment 100 percent of the time?

Ms. DAVIS. Yes, I do. Again, I think that the incentives for signing up for participation or nonparticipation clearly are there. If you allow for all individuals to not have a freeze, then I think you are going against that incentive. It is true that the volume of claims that are being accepted under assignment has been going up, and we are very pleased with that.

But I think here again our initial commitment was to recognize that those who participated would be exempt and would be able to have their charges increase, and we think that it is important to honor that. I would be concerned about making it across the board.

Mr. WHITTAKER. The Deficit Reduction Act that did establish national fee schedules for independent clinical laboratories and regional fee schedules for the hospital-based labs was enacted sometime back. Since that enactment, have more physician office labs been established? And following that, would you care to comment on your opinion as to whether the assignment for lab services performed in a physician's office increased during the past year?

Ms. DAVIS. The assignment level for the nonphysician areas has clearly increased. But of course, the laboratory fees were a mandate for assignment. I am not sure we have the data as to whether the number of physicians who are incorporating new labs has gone up.

We will search our records, and if we have anything, we will submit it for the record.

[Information to be furnished follows:]

"We do not regulate physician's office labs and, therefore, do not capture this data."

Mr. WHITTAKER. I would appreciate that.

The Inspector General has recommended the mandatory second opinion. Do you think this should be implemented on a demonstration basis prior to full-scale implementation through the Medicare Program?

Ms. DAVIS. I certainly think that it would be better for us to do a demonstration to define for certain whether or not we even need to do that. Clearly, existing data was based on some studies that were done prior to the implementation of the peer review organizations. I think the peer review organizations are very aggressive in their monitoring, so I believe that it would be more appropriate to test whether or not it needs to be done rather than to move into an absolute second opinion program across the board.

Mr. WHITTAKER. Does HCFA support the inspector general's recommendation to not cover assistant surgeon surgery during cataract surgery without prior approval?

Ms. DAVIS. In the majority of cases that would be appropriate. I believe his intent was along the same lines as ours. It was just a different way of arriving at the same idea. We discussed whether or not we would want to move to promulgate a national policy or simply to try for more uniform handling of claims. Some of our carriers are indeed very aggressive. Others have not been. We have been pushing those who have not been aggressive to disallow payment any time that there was not adequate documentation.

A careful approach would indicate that there will be specific times when some patients, because of other medical problems, would need an assistant at surgery. But that should be well documented ahead of time.

Mr. WHITTAKER. Later on in the hearing my good friend Representative Wyden is going to be speaking about a couple of bills he has introduced. But I would be curious about your opinion on H.R. 2864, dealing with Medicare part B appeal procedures, and then H.R. 2293, dealing with long-term care insurance.

Have HCFA and the Department of HHS taken a position on these bills?

Ms. DAVIS. Let me deal with the two separate bills here. The first one, the appeals process component, I was checking to see if we had officially announced our position. Yes, we did oppose that particular bill and the appeals process during the discussions last week, I think, with the Ways and Means Committee during their markup. We believe that it is premature to make a decision without holding hearings on this very complex area, the whole issue of the appeals process. Because of that, the feeling that we needed hearings, we could not support this bill.

Mr. WAXMAN. Isn't this a hearing on the issue?

Ms. DAVIS. That is true. However, I think that we had figured that there should be a hearing on simply that alone, not integrated with a whole lot of other areas. I would be somewhat concerned without taking a more careful look at how we could prevent certain providers from, in effect, being in a conflict-of-interest position where they would be recommending certain appeal processes to beneficiaries.

We do have cases now where I have found that a beneficiary has been solicited to appeal by the providers. I would have some concern.

Mr. WYDEN. If the gentleman would yield very briefly.

What kind of a conflict situation could there be when a provider and a consumer work together, Dr. Davis, filing an appeal? You know, for example, that the coalition that supports the changes in

appeals includes everyone from the American Medical Association to the Gray Panthers and AARP. They clearly do not see that there is any conflict, although I know that the administration made that argument. Describe where there could be a conflict. We have asked, and we have not had one case of a conflict ever pointed out.

Mr. WAXMAN. Before you answer that question, the gentleman's time has expired. We have too long an agenda, and this will be on your time.

Ms. DAVIS. I will submit it for the record, or if you want to ask me later.

[The following information was submitted for the record:]

The most significant reason for opposing a bill which would provide statutory authority for providers to represent beneficiaries in the appeals process, is found in Section 1870 of the Act. This provision stipulates that a beneficiary, rather than a provider, shall be considered to have been overpaid if the provider can show it was without fault and acted in good faith.

Further, a serious conflict of interest arises in instances where a provider represents a beneficiary in pursuing a claim under Section 1879(b). This section requires the Secretary, in cases where a provider knew or could reasonably be expected to know that payment would not be made for services, to reimburse the beneficiary for payment made to the provider. This payment is then treated as an overpayment and is recoverable from the provider.

Mr. WYDEN. One change that concerns me, Dr. Davis, is that you want to increase the part B premium and generate 3-year savings of \$3.2 billion by increasing the part B premium. We know that probably 20 percent of the senior citizens in this country are low income and are walking on economic tightropes. Isn't that going to hurt them? What kind of a protection is there going to be for the low-income seniors under your proposal to increase the part B premium?

Ms. DAVIS. As you will recall, the intent when we increased this was to move it back toward what Congress had initially intended, which was to, in effect, have it represent more, up to a certain percentage, of the total outlays.

Our estimate is that, if we accomplish all of the freeze that we have proposed, the premium increase would amount to about 70 cents a month. And furthermore, there is a hold-harmless provision so that beneficiaries would not get less in their Social Security check than what they had this year. We think that is the important component within this proposal.

I think it is important to recognize that when Congress initially passed legislation, 50 percent of the outlays were to be calculated and paid for by premiums; and that over time has—is there such a word as “deescalate”?—that has dwindled to only 25 percent. If we don't do something, it can go down to 21 percent. So our proposal is to increase it up by 2 percent a year until it reaches 35 percent.

Mr. WYDEN. If you would furnish that to the committee as well in writing. It is hard to see how you can save \$3.2 billion over 3 years and still make it such a tiny increase. It is my understanding that it was quite a bit larger.

[The following information was submitted for the record:]

Under the Administration's proposal, the percentage of aged program costs financed by the Part B premium would be increased from 25 percent to 35 percent by

1990 in increments of two percentage points beginning in 1986. This will result in three-year savings of \$3.2 billion.

Assuming enactment of the Administration's other Part B proposals, the difference between the current law premium and the premium under this proposal is 70¢ in 1986 and \$5.40 in 1988.

Most low income beneficiaries, who are receiving Medicaid would not be affected by this proposal since the premium is paid by the Medicaid program.

No individual would see a reduction in their Social Security check as a result of the premium increases under this proposal because of a hold-harmless provision for individuals who have their premium deducted directly from their monthly Social Security payment.

The Part B premium was originally designed to finance 50 percent of program costs. If no change is made to current law, the premium will cover less than 21 percent of aged program costs by 1990. With the proposed change, in 1990 for every \$1 in premium payments, the average beneficiary will receive \$3 in benefits.

Mr. WYDEN. There is another area that I wanted to ask about, Dr. Davis. As you know, in the last Congress I was a principal sponsor of the Fair Lab Payments Act with respect to laboratory services. One of the things that a number of members and staff have noted is that now there is an extraordinary variation in local fee schedules for laboratory tests around the country. Typically, it can be on the order of 100 or 200 percent, sometimes even greater. We know it cannot just be due to wage considerations and that kind of thing.

What we are hearing from members and staff is that they question whether we should do an across-the-board freeze under these kinds of circumstances when you seem to have such inequities built into the fee schedule. And what they have said instead is, "Why don't we have a reduction in the highest fees so as to save the Government some money, No. 1, and also produce some equity in the system?"

What would you think of that kind of idea?

Ms. DAVIS. It seems to me that is rather a subjective judgment that one would be making on what one would, in effect, hold down or what you would allow to move upward. I believe that the initial congressional intent was to move to a national fee schedule, and it seems like that would address the problem. In the meantime, I think a simple freeze is a recognition that again we are asking everyone to participate equally in holding down the overall costs of inflation.

I would point out that these kinds of inequities have been in the system under the reasonable charge system. That is what has happened over years as we got all of these funny-looking differences around the country. The national fee schedule may be the appropriate way to resolve that.

Mr. WYDEN. I think my time has almost expired.

My concern with your freeze approach is that I think it is just too simplistic. It freezes all of the inequities, all of the various aspects of unfairness which we now have got in the system and just puts off the day when we have real reform. I think we are seeing that in the lab area. We are seeing it in some of the useful questions asked by the chairman. I think it is a mistake.

I think the reforms that we started that had bipartisan support in 1983 ought to go forward. Just to say let's blindly go out and freeze everything does produce some short-term savings, but seniors are going to get hurt and I think that we're going to see pro-

viders in a lot of inner cities and rural areas who aren't going to be able to give the care.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. Nielson.

Mr. NIELSON. I will not take the full 5 minutes.

I am concerned about the physician freeze, another extension, in view of the fact that we don't freeze anything that constitutes his fee; for example, malpractice insurance has gone up double, triple, some cases five times in the last couple of years. What is your agency trying to do about the malpractice insurance? Do you think anything could be done to maybe hold that one down a little bit since that is an integral part of the physician's cost?

Ms. DAVIS. We are just beginning to collect some data as it relates to the malpractice cost issue. I think it is quite significant. The small amount of data that we have so far indicates there is enormous variation in the cost. The increases are not the same across all parts of the country or all specialty areas. It is difficult to come up with a conclusion of how one can fix it.

I do know that about 75 percent of all of the physicians have malpractice premiums that are under \$10,000 a year. We can give you some other data if you are interested in that.

Mr. NIELSON. Would you supply it for the record?

Ms. DAVIS. Certainly.

[Information to be furnished follows:]

Several important facts are relevant for any discussion of physician's malpractice costs and Medicare:

Malpractice is a relatively small expense when compared with a physician's gross income. Medical Economics survey data indicate that malpractice costs are less than three percent of the average physician's gross practice receipts. Preliminary data from a HCFA sponsored survey, conducted by the National Opinion Research Corporation (NORC), suggest that in 1984 malpractice costs for the average physician was \$6,200.

Malpractice costs vary substantially among physicians. Preliminary HCFA-NORC survey results suggest that in 1984, 75 percent of physicians had malpractice costs of less than \$10,000. Moreover, malpractice costs exceed five percent of gross practice receipts only in the specialties of obstetrics, neurosurgery and thoracic surgery. Of all Medicare spending for physicians' services, obstetricians account for less than 1 percent, neurological surgeons account for 1.1 percent and thoracic surgeons account for 3.3 percent.

Mr. NIELSON. We had a hearing the other day related to this on the prescription drugs, the huge increase in prescription drugs. And since they are part of part A in the Medicare costs in part A have not been as much as part B, how do you account for that? That is the biggest single component of medical cost increase, and yet part A, which contains it, has not grown as much as part B.

Ms. DAVIS. I think probably because it is incorporated within the PPS system. The DRG system itself pays one payment and the drug must be within that.

Mr. NIELSON. Have you thought of any way you can apply the same kind of control to part B, other than straight freeze, which, as Congressman Wyden says, it freezes what is there?

Ms. DAVIS. We do not pay for many of the drugs under part B because that would be an outpatient service, and our general Medicare program does not recognize that.

Mr. NIELSON. You have some controls on part A. You have held it down. You have held the cost increase lower than part B. Is there something comparable you can do for part B costs?

Ms. DAVIS. Yes. It is clear that Congress has a great interest in making very significant reform in how we pay under part B. A reasonable charge system is very inflationary, and we are all coming to understand that now that we have got the part A fixed and we see part B is still escalating at 15 to 20 percent a year. We will have a proposal up to Congress shortly looking at a variety of options for how one can tackle the long-range policy issues as they deal with the physician area and other areas.

So I think I would suggest again that the freezes are a temporary measure for 1 year until we get the report submitted. And if Congress has ample time to study it and having hearings on what the appropriate way is to resolve the problem—

Mr. NIELSON. In 30 seconds or less, did you hear Congresswoman Kennelly's remarks? Do you agree with her statement that a lot of the elective surgery, like vasectomies and other things are not necessary?

Ms. DAVIS. I think there are enormous variations in practice patterns, but that is why we have intensive review by the peer review organizations. Each peer review organization must look at at least 5 out of the top 20 procedures in their State in a preadmission review. In the other ones, they are looking at randomly one-third of all admissions. So I think that we are having a very heavy effect from the aggressive posture of the peer review organizations.

Mr. NIELSON. I thank you, Dr. Davis.

Mr. WAXMAN. Thank you, Mr. Nielson.

Mr. Tauke.

Mr. TAUKE. Thank you, Mr. Chairman.

First, Dr. Davis and Congressman Nielson, I have to say I shudder a little bit when I hear you suggest that the part A problem is fixed. But we will take that up at another time.

Mr. NIELSON. Less fast growing than part B.

Mr. TAUKE. Let me address first of all the physician fee freeze issue. There are a couple of concerns that I have relating to that.

First of all, I wonder if any consideration has been given to an adjustment for physicians who were entering practice at the time the freeze first went into effect. They came in at the 50th percentile level for a year, and then that was extended an additional 15 months, and now if we freeze again it will go for another year. Is anybody looking at those people who did not have a previous record and, therefore, got brought in at that 50th percentile level?

Ms. DAVIS. I do not believe that we had made any recommendations to make any changes and treat them differently than we had any of the other ones.

Mr. BOOTH. May I add, sir, that in some cases the 50th percentile that the physicians were being paid was higher than the prevailing charge, and so they really were not being penalized in a number of cases. There were some who were receiving less than the prevailing charge, but in many cases they were doing well indeed.

Mr. TAUKE. In any event, I gather you have not really looked at that question.

Mr. BOOTH. Not specifically.

Mr. TAUKE. Have you taken any look at the fee schedule for hospital-based physicians? We get reports—I don't know how complete they are—that suggest that those hospital-based physicians have fee schedules that are widely varying from State to State and from area to area. Do you have any observations on that, and is any look being given at that issue?

Ms. DAVIS. You put your finger on a very important point, and that is that fees in general vary widely within the same specialty between States and certainly they vary between specialties who do the same procedure. That is part of the whole complexity of dealing with an equitable treatment of all physicians and why we need one more year before we are ready to move forward with some total reform proposals.

Mr. TAUKE. Do you know how many doctors are in a position where they have accepted assignment 100 percent of the time but have chosen not to become participating physicians for philosophical reasons or other reasons? Would you have that data available?

Ms. DAVIS. I don't know that we can track it by that degree of specificity. Let me check again to be sure.

Mr. TAUKE. You don't have any way of knowing that?

Ms. DAVIS. No, we don't.

Mr. TAUKE. There are some who have contended that they accept 100 percent of the assignment but do not for philosophical reasons want to sign on the dotted line. And apparently, under the budget agreements, they will be somewhat penalized.

Ms. DAVIS. We would need to have an individual physician number to track. The problem is we do not keep our records by individual physician numbers.

Mr. TAUKE. On lab fee schedules, I understand that we have had some complaints, first of all, that the lab fee schedules are antiquated, that certain reimbursements are provided for certain tests that are no longer done, and they have new tests to replace them and so on. Is anybody looking at that question?

Mr. BOOTH. We are looking at updating the whole procedure coding system on a periodic basis. To the extent that tests are no longer done, those procedures simply do not come into us, and they drop off the reimbursement schedules. It is more a function of what tests come on and take their place.

Mr. TAUKE. More significantly—and you would not have expected me to finish this question period without asking something rural—but the smaller independent labs that serve particularly rural hospitals apparently feel that they incur greater costs for certain tests because they have, first of all, to have a wide variety of testing available, and yet they do not use certain of the tests very often. They have transportation costs involved, and other things that the larger labs that may specialize and not have a full range of services do not have.

Hospital-based labs have also shared this concern, and I wonder if any consideration has been given to providing some relief for some of these smaller full-service labs, which are attempting to compete with larger labs with more narrow offerings?

Ms. DAVIS. I don't believe so.

Mr. BOOTH. I question that a little bit. The vast proportion of all laboratory services are comprised of the top 90 or 100 tests that are

done. Once you get beyond that, the level or the volume of testing drops considerably. And the last 400 or 500 lab tests that are done in terms of order of volume are done relatively infrequently, and many of them are done by very few specialty labs, half a dozen or so in the United States.

I think your constituents may be overstating the case, but I would look at any particular problems that they are having.

Ms. DAVIS. We also have a regulation that we are now in the process of developing that speaks to the high-cost, low-volume tests, and perhaps that might resolve some of that problem, too.

Mr. TAUKE. I thank you for your responses. There are a number of things which we could have followed up on, and I think I will send you a letter or two.

Ms. DAVIS. Fine.

Mr. WAXMAN. If the gentleman wishes, we will hold the record open to include both the letter and the responses so the rest of us can share in those views.

Thank you very much, Dr. Davis, and the others with you. We appreciate your testimony.

I would like now to call forward Richard P. Kusserow, inspector general, Department of Health and Human Services. Your prepared statement will be made part of the record in full. We would like you to summarize it in 5 minutes. We need to be strict in our limits in order to try to go through the whole agenda we have before us.

STATEMENT OF RICHARD P. KUSSEROW, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. KUSSEROW. Thank you, Mr. Chairman and members of the committee. I am Richard Kusserow, inspector general for the Department of Health and Human Services. With me is deputy assistant inspector general for audits, Larry Simmons.

In March of this year, we testified before the Senate Aging Committee on our report on a mandatory second surgical opinion program. Like you, we have long been concerned that unnecessary surgery might be wasting American lives and dollars. In January 1976, the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce reported that an estimated 2.4 million unnecessary surgeries had been performed in 1974 at a cost of 11,900 lives and \$4 billion. The House report concluded that second opinion consultations cut down significantly on unnecessary surgery.

In response to that committee report, HHS launched a voluntary national second opinion program in 1977, the main objective being to decrease the amount of inappropriate surgery performed, thereby avoiding the costs and risks of surgery without jeopardizing the health and well-being of patients.

The Health Care Financing Administration, HCFA, also encouraged States to pay for second surgical opinions under Medicaid. Seven States went further by requiring mandatory second surgical opinion programs in which recipients were required to obtain second opinions for selected surgical procedures as a condition of Medicaid coverage.

Under each of these mandatory programs, the decision to have or not have the elective surgery still rested with the Medicaid recipient. A dissenting second opinion had no effect on coverage if the recipient chose to have the surgery performed.

In 1983, we completed a review of second surgical opinion programs that we made in order to see what effect they were having on the numbers of elective surgeries in Medicare and Medicaid.

We wanted to know whether or not such programs worked and, if so, what type worked best.

As our report will show, we concluded that Medicare's voluntary second surgical opinion program was not having the desired effect, but that Medicaid's mandatory programs were reducing the number of elective surgeries.

A major reason for this difference is that effects of mandatory programs are enhanced by what is known as the "sentinel effect." This is a phenomenon whereby physicians initially recommend fewer surgeries because they know that their decisions to operate will be reviewed by other physicians. Since most patients are reluctant to seek second opinions on their own volition, the "sentinel effect" will not come into play to any significant degree until a mandatory second opinion program is implemented for certain elective surgeries.

We do not propose mandating this for other types of surgeries, nor do we suggest that a second opinion should preclude a beneficiary from going ahead with a decision to have surgery where there is a differing opinion. We only want to insure that the beneficiary has a sufficient amount of data with which to make an informed judgment on the necessity of surgery.

Two years ago we were convinced that second opinions were good for patients. Available data also showed that mandatory Medicaid second opinion programs were feasible and could result in significant savings. We estimated that \$60 million per year or \$300 million over a single 5-year budget cycle could be saved if all States were required to implement mandatory programs. For Medicare, we have estimated that such a program could save over \$100 million per year, depending upon the surgical procedures included.

Since we issued that report in 1983, HCFA has taken the position that there was need for further study and analysis before such a policy could be implemented. However, we believe that this matter has been studied enough. In our report and previous testimony before the Senate Aging Committee, we cited 10 studies on this subject, as listed in the attachments to our written statement, over the past 4 years. HCFA funded all or part of 8 of the 10 studies. All of them support mandatory second surgical opinions as cost-effective and desirable.

Further, our conviction that mandatory second surgical opinion programs are needed to reduce the rate of elective surgery is strengthened by the growing momentum of these programs in the private sector. According to the Blue Cross and Blue Shield Association, mandatory programs have grown tremendously in the coverage provided by their member plans. For example, in 1982, only 10 plans included mandatory coverage; today, about 60 insurance plans administered by Blue Cross and Blue Shield member plans require second opinions prior to elective surgery.

In summary, let me say that all the evidence supports two central findings: One, program participants do not obtain second opinions under voluntary programs, and two, mandatory programs are cost effective.

Mr. Chairman, we believe that all the data correctly indicates that mandatory second surgical opinion programs could reduce the number of elective surgeries that are undesirable or unnecessary in Medicaid, and in Medicare, and would also result in considerable savings for these programs.

Now I would like to discuss our findings in our recently issued audit report, "Review of Medicare Payments for Assistant Surgeon Services During Cataract Surgery."

Health insurance for the aged and disabled allows for surgical procedures, including ophthalmic surgery, under the Medicare part B program. Cataract surgery, the most commonly performed of the ophthalmic surgeries, involves extracting from the eye, the lens which has become cloudy or opaque. Several different extraction methods may be used, usually with a local anesthetic. They are routinely performed within an hour, most often involving implantation of a plastic ocular lens. Cataract surgery is considered under most circumstances to be an elective surgery and therefore is generally not performed under emergency conditions.

Currently, HCFA permits the Medicare part B carriers to make determinations as to whether or not the services of assistant surgeons during cataract surgery are medically necessary, and whether charges for these services are covered by the program. For the most part, each carrier makes these determinations based on the practice of ophthalmologists in the geographic area serviced. Our review concluded that the services of an assistant surgeon at these operations are not necessary and ought not be covered by Medicare except in highly unusual circumstances.

Thank you, Mr. Chairman.

[Mr. Kusserow's prepared statement follows:]

TESTIMONY
OF
RICHARD P. KUSSEROW

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I AM RICHARD P. KUSSEROW, INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. WITH ME TODAY IS LARRY SIMMONS, OUR DEPUTY ASSISTANT INSPECTOR GENERAL FOR AUDITS. WE ARE HERE TO DISCUSS OUR AUDITS ON MANDATORY SECOND SURGICAL OPINION PROGRAMS AND ON MEDICARE PAYMENTS FOR ASSISTANT SURGEON SERVICES DURING CATARACT SURGERY. WITH YOUR PERMISSION, I WILL SUBMIT BOTH OF THESE REPORTS FOR THE RECORD.

IN MARCH OF THIS YEAR, WE TESTIFIED BEFORE THE SENATE AGING COMMITTEE ON OUR REPORT ON A MANDATORY SECOND SURGICAL OPINION PROGRAM. LIKE YOU, WE HAVE LONG BEEN CONCERNED THAT UNNECESSARY SURGERY MIGHT BE WASTING AMERICAN LIVES AND DOLLARS. IN JANUARY 1976, THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE REPORTED THAT AN ESTIMATED 2.4 MILLION UNNECESSARY SURGERIES HAD BEEN PERFORMED IN 1974 AT A COST OF 11,900 LIVES AND \$4 BILLION. THE HOUSE REPORT CONCLUDED THAT SECOND CONSULTATIONS COULD CUT DOWN SIGNIFICANTLY ON UNNECESSARY SURGERY.

IN RESPONSE TO THIS COMMITTEE REPORT, HHS LAUNCHED A VOLUNTARY NATIONAL SECOND OPINION PROGRAM IN 1977, THE MAIN OBJECTIVE BEING TO DECREASE THE AMOUNT OF INAPPROPRIATE SURGERY PERFORMED THEREBY AVOIDING THE COSTS AND RISKS OF SURGERY WITHOUT JEOPARDIZING THE HEALTH AND WELL-BEING OF PATIENTS. THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) ALSO ENCOURAGED STATES TO PAY FOR SECOND SURGICAL OPINIONS UNDER MEDICAID. SEVEN STATES

WENT FURTHER BY REQUIRING MANDATORY SECOND SURGICAL OPINION PROGRAMS IN WHICH RECIPIENTS WERE REQUIRED TO OBTAIN SECOND OPINIONS FOR SELECTED SURGICAL PROCEDURES AS A CONDITION OF MEDICAID COVERAGE. UNDER EACH OF THESE MANDATORY PROGRAMS, THE DECISION TO HAVE OR NOT HAVE THE ELECTIVE SURGERY STILL RESTED WITH THE MEDICAID RECIPIENT. A DISSENTING SECOND OPINION HAD NO EFFECT ON COVERAGE IF THE RECIPIENT CHOSE TO HAVE THE SURGERY PERFORMED.

IN 1983, WE COMPLETED A REVIEW OF SECOND SURGICAL OPINION PROGRAMS THAT WE MADE TO SEE WHAT AFFECT THEY WERE HAVING ON THE NUMBERS OF ELECTIVE SURGERIES IN MEDICARE AND MEDICAID.

WE WANTED TO KNOW WHETHER OR NOT SUCH PROGRAMS WORKED AND IF SO, WHAT TYPE WORKED BEST.

AS OUR REPORT WILL SHOW, WE CONCLUDED THAT MEDICARE'S VOLUNTARY SECOND SURGICAL OPINION PROGRAM WAS NOT HAVING THE DESIRED AFFECT, BUT THAT MEDICAID'S MANDATORY PROGRAMS WERE REDUCING THE NUMBER OF ELECTIVE SURGERIES.

A MAJOR REASON FOR THIS DIFFERENCE IS THAT EFFECTS OF MANDATORY PROGRAMS ARE ENHANCED BY WHAT IS KNOWN AS THE "SENTINEL EFFECT". THIS IS A PHENOMENON WHEREBY PHYSICIANS INITIALLY RECOMMEND FEWER SURGERIES BECAUSE THEY KNOW THAT THEIR DECISIONS TO OPERATE WILL BE REVIEWED BY OTHER PHYSICIANS. SINCE MOST PATIENTS ARE RELUCTANT TO SEEK SECOND OPINIONS ON THEIR OWN

VOLITION, THE "SENTINEL EFFECT" WILL NOT COME INTO PLAY TO ANY SIGNIFICANT DEGREE UNTIL A MANDATORY SECOND OPINION PROGRAM IS IMPLEMENTED FOR CERTAIN ELECTIVE SURGERIES. WE DO NOT PROPOSE MANDATING THIS FOR OTHER TYPES OF SURGERIES, NOR DO WE SUGGEST THAT A SECOND OPINION PRECLUDE A BENEFICIARY FROM GOING AHEAD WITH A DECISION TO HAVE SURGERY WHERE THERE IS A DIFFERING OPINION. WE ONLY WANT TO INSURE THE BENEFICIARY HAS A SUFFICIENT AMOUNT OF DATA WITH WHICH TO MAKE AN INFORMED JUDGEMENT ON THE NECESSITY OF SURGERY.

TWO YEARS AGO WE WERE CONVINCED THAT SECOND OPINIONS WERE GOOD FOR PATIENTS. AVAILABLE DATA ALSO SHOWED THAT MANDATORY MEDICAID SECOND OPINION PROGRAMS WERE FEASIBLE AND COULD RESULT IN SIGNIFICANT SAVINGS. WE ESTIMATED THAT \$60 MILLION PER YEAR OR \$300 MILLION OVER A SINGLE FIVE-YEAR BUDGET CYCLE, COULD BE SAVED IF ALL STATES WERE REQUIRED TO IMPLEMENT MANDATORY PROGRAMS. FOR MEDICARE, WE HAVE ESTIMATED THAT SUCH A PROGRAM COULD SAVE OVER \$100 MILLION PER YEAR - DEPENDING UPON THE SURGICAL PROCEDURES INCLUDED.

SINCE WE ISSUED THAT REPORT IN 1983, HCFA HAS TAKEN THE POSITION, THAT THERE WAS NEED FOR FURTHER STUDY AND ANALYSIS BEFORE SUCH A POLICY COULD BE IMPLEMENTED. HOWEVER, WE BELIEVE THAT THIS MATTER HAS BEEN STUDIED ENOUGH. IN OUR REPORT AND PREVIOUS TESTIMONY BEFORE THE SENATE AGING COMMITTEE, WE CITED 10 STUDIES ON THIS SUBJECT (SEE ATTACHMENTS) OVER THE PAST FOUR

YEARS. HCFA FUNDED ALL OR PART OF 8 OF THE 10 STUDIES. ALL OF THEM SUPPORT MANDATORY SECOND SURGICAL OPINIONS AS COST EFFECTIVE AND DESIREABLE. FURTHER, OUR CONVICTION THAT MANDATORY SECOND SURGICAL OPINION PROGRAMS ARE NEEDED TO REDUCE THE RATE OF ELECTIVE SURGERY IS STRENGTHENED BY THE GROWING MOMENTUM OF THESE PROGRAMS IN THE PRIVATE SECTOR. ACCORDING TO THE BLUE CROSS AND BLUE SHIELD ASSOCIATION, MANDATORY PROGRAMS HAVE GROWN TREMENDOUSLY IN THE COVERAGE PROVIDED BY THEIR MEMBER PLANS. FOR EXAMPLE, IN 1982, ONLY 10 PLANS INCLUDED MANDATORY COVERAGE; TODAY, ABOUT 60 INSURANCE PLANS ADMINISTERED BY BLUE CROSS AND BLUE SHIELD MEMBER PLANS REQUIRE SECOND OPINIONS PRIOR TO ELECTIVE SURGERY.

IN SUMMARY, LET ME SAY THAT ALL THE EVIDENCE SUPPORTS TWO CENTRAL FINDINGS:

- (1) PROGRAM PARTICIPANTS DO NOT OBTAIN SECOND OPINIONS UNDER VOLUNTARY PROGRAMS;
- (2) MANDATORY PROGRAMS ARE COST EFFECTIVE.

MR. CHAIRMAN, WE BELIEVE THAT ALL THE DATA CORRECTLY CONCLUDES THAT MANDATORY SECOND SURGICAL OPINION PROGRAMS COULD REDUCE THE NUMBER OF ELECTIVE SURGERIES THAT ARE UNDESIRABLE OR UNNECESSARY IN MEDICAID, AND IN MEDICARE, WHICH WOULD ALSO HAVE THE EFFECT OF CONSIDERABLE SAVINGS FOR THESE PROGRAMS.

NOW, I WOULD LIKE TO DISCUSS OUR FINDINGS IN OUR RECENTLY ISSUED AUDIT REPORT...REVIEW OF MEDICARE PAYMENTS FOR ASSISTANT SURGEON SERVICES DURING CATARACT SURGERY.

HEALTH INSURANCE FOR THE AGED AND DISABLED ALLOWS FOR SURGICAL PROCEDURES, INCLUDING OPHTHALMIC SURGERY, UNDER MEDICARE PART B PROGRAM. CATARACT SURGERIES, THE MOST COMMONLY PERFORMED OF THE OPHTHALMIC SURGERIES, INVOLVE EXTRACTING FROM THE EYE, THE LENS WHICH HAS BECOME CLOUDLY OR OPAQUE. SEVERAL DIFFERENT EXTRACTION METHODS MAY BE USED, USUALLY WITH A LOCAL ANESTHESIA. THEY ARE ROUTINELY PERFORMED WITHIN AN HOUR; MOST OFTEN INVOLVING IMPLEMENTATION OF A PLASTIC MOCULAR LEN. CATARACT SURGERY IS CONSIDERED UNDER MOST CIRCUMSTANCES, TO BE AN ELECTIVE SURGERY AND THEREFORE, IS GENERALLY NOT PERFORMED UNDER EMERGENCY CONDITIONS.

CURRENTLY, HCFA PERMITS THE MEDICARE PART B CARRIERS TO MAKE DETERMINATIONS AS TO WHETHER OR NOT THE SERVICES OF ASSISTANT SURGEONS DURING CATARACT SURGER ARE MEDICALLY NECESSARY, AND WHETHER CHARGES FOR THESE SERVICES ARE COVERED BY THE PROGRAM. FOR THE MOST PART, EACH CARRIER MAKES THESE DETERMINATIONS BASED ON THE PRACTICES OF OPHTHALMOLOGISTS IN THE GEOGRAPHIC AREA SERVICED.

BASED ON HCFA PART B EXPENDITURE REPORTS, WE CALCULATED THAT MEDICARE PART B PAYMENTS DURING CY 1983, OUR MOST RECENT DATA,

FOR OPHTHALMOLOGY SERVICES BY SURGEONS AND ASSISTANT SURGEONS AMOUNTED TO \$822 MILLION AND \$42 MILLION, RESPECTIVELY. WHILE THESE FIGURES REFLECT ALL EYE SURGERY PROCEDURES, OUR ANALYSIS OF PAYMENT DATA OBTAINED FROM FIVE CARRIERS SHOWS THAT ABOUT 90% OF THESE PAYMENTS WERE RELATED TO CATARACT SURGERY.

WHEN WE UNDERTOOK OUR REVIEW, WE WANTED TO DETERMINE WHETHER THE SERVICES OF AN ASSISTANT SURGEON DURING CATARACT SURGERY ARE MEDICALLY NECESSARY IN VIEW OF THE DIVERSITY IN POLICY FROM CARRIER TO CARRIER.

TO MEET THIS OBJECTIVE, WE MADE A REVIEW OF CURRENT MEDICAL PRACTICES, CARRIER'S COVERAGE POLICIES AND NATIONAL COVERAGE GUIDELINES. OUR REVIEW FOUND THAT ALTHOUGH THE PRIMARY OPHTHALMIC SURGEON REQUIRES ASSISTANCE DURING ROUTINE CATARACT SURGERY, SUCH ASSISTANCE IS OFTEN PROVIDED BY A SURGICAL TECHNICIAN AND/OR OPERATING ROOM NURSE. IN THIS KIND OF MICROSCOPIC SURGERY, A SECOND SURGEON IS GREATLY LIMITED IN WHAT THEY CAN DO. IN NINE STATES, WE FOUND THAT AN ASSISTANT SURGEON IS NOT MEDICALLY NECESSARY DURING ROUTINE CATARACT SURGERY, AS EVIDENCED BY THE PRACTICES OF MANY PRIMARY OPHTHALMIC SURGEONS WHO DO NOT USE THEM AND THE RESTRICTIVE COVERAGE POLICIES OF MEDICARE CARRIERS IN NINE STATES.

OUR REPORT CONCLUDED THAT MEDICARE PROGRAM SAVINGS OF \$150

MILLION TO \$200 MILLION COULD BE ACHIEVED IN A SINGLE FIVE YEAR BUDGET CYCLE. IF HCFA PROMULGATES A NATIONAL POLICY TO EXCLUDE MEDICARE COVERAGE OF ASSISTANT SURGEONS' CHARGES ON ROUTINE CATARACT OPERATIONS. WE ALSO RECOMMENDED TO HCFA THAT MEDICARE POLICY SHOULD PROVIDE THAT IN CERTAIN INSTANCES WHERE OTHER MEDICAL CONDITIONS EXIST, AS SPECIFIED BY HCFA, THE PRIMARY OPHTHALMIC SURGEON SHOULD JUSTIFY OR OBTAIN PRIOR APPROVAL OF THE USE OF AN ASSISTANT SURGEON.

HCFA AGREES WITH OUR FINDINGS, BUT DISAGREED WITH OUR RECOMMENDATIONS, TO EXCLUDE BY INSTRUCTION ROUTINE COVERAGE FOR ASSISTANT SURGEON COVERAGE. THEY PROPOSED INSTEAD, TO HANDLE THE PROBLEM THROUGH THE LESS FORMAL PROCESS OF BETTER EDUCATION OF THE MANNER OF PROCESSING OF CLAIMS UNDER HCFA'S CURRENT POLICY. IN OUR JUDGMENT THIS IS AN UNNECESSARILY SLOW PROCESS THAT MAY NOT RESULT IN COMPLETE COMPLIANCE BY ALL CARRIERS.

I WOULD ADD THAT NO FINAL DETERMINATION HAS BEEN MADE BY THE DEPARTMENT AS TO THE APPROPRIATE COURSE OF ACTION.

MR. CHAIRMAN, THIS CONCLUDES MY TESTIMONY ON OUR TWO REPORTS. I AM READY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Major Studies on Second Surgical Opinion Programs

1. 3/81 — HCFA — Analysis of Eight Years Experience of One Program
2. 9/81 — ABT ASSOCIATES — On Mandatory and Voluntary Alternatives
3. 11/81 — MICHIGAN — On Its Mandatory Program
4. 12/81 — WISCONSIN — On Its Medicaid SSOP Program
5. 1/82 — MARTIN, SHWARTZ, ET. AL. — Impact of Mandatory Program on Medicaid Surgery
6. 3/82 — HHS — Medicare Voluntary Programs — Effect of Waiving Cost Sharing
7. 11/82 — POGGIO AND GOLDBERG — Mass. Mandatory Program
8. 11/82 — CENTER FOR POLICY RESEARCH, NAT'L GOVERNORS' ASSN. — Controlling Medicaid Costs: SSOPs
9. 11/84 — MCCARTHY, KERSHAW & RUCHLIN — Mandatory Second Opinion for Elective Surgery
10. 12/84 — ABT ASSOCIATES — SSOPs: Public Policy Alternatives

Capsule of Findings: Major Studies on Second Surgical Opinion Programs

[illegible]

Mr. WAXMAN. There is considerable difference of opinion as to whether the program saves money. Should we have a mandatory program even if there are little or no savings?

Mr. KUSSEROW. Yes; the evidence is not only that there would be enormous savings to the program from reduced elective surgeries, but the fact is that it is more helpful for the beneficiaries to have the benefit of the second opinion before taking that serious step.

Elderly patients are particularly vulnerable to surgery as a risk, and to give them all of the information that we can is something that I think we owe them morally not to mention the savings that would be effected by a program like that.

Mr. WAXMAN. What should we do to protect the beneficiary in the situation where the Medicare does not pay for the assistant in surgery but the primary surgeon insists on using one?

Mr. KUSSEROW. I do not believe—you would have to have the beneficiary pick up the tab. We only pay for what is reasonable and necessary, and if indeed it is not necessary, then the physician that cannot make a case for it should be the one who should pick up the tab and not the beneficiary.

Mr. WAXMAN. Over the last few years you have made a number of other recommendations for improvements in savings in the Medicare Program. If you wish to submit a statement for the record summarizing these recommendations, we would be happy to review it carefully.

Mr. KUSSEROW. Thank you, Mr. Chairman. We would be happy to do that.

Mr. WAXMAN. Mr. Whittaker.

Mr. WHITTAKER. You have recommended that when certain medical conditions exist, that assistant surgeons should be approved of. Who do you think will make the approval determination?

I am curious about your answer as to whether you think it is going to be the Medicare carrier or the local peer review organization, and depending on that, how long do you think that this would delay the operation?

Mr. KUSSEROW. Any case where there is other than elective situations existing, if there is not an elective situation, where there is an emergency, then you go ahead with it without waiting for that kind of a determination. But if you have an elective situation, then it is up to the surgeon to make the case as to why it's necessary to have an assistant surgeon. And indeed, if they make that case, then they can go ahead and do that and it can be done in an inpatient capacity by a peer review organization. But, currently, we cannot do that under peer review for outpatient surgery.

Mr. WHITTAKER. To whom would they make their case?

Mr. KUSSEROW. To the carrier, initially, that there was an unusual circumstance that would warrant having an assistant surgeon.

Mr. WHITTAKER. If the use of assistant surgeons in cataract surgery more prevalent in certain regions of the country or in teaching hospitals versus community hospitals?

Mr. KUSSEROW. We found that where we encountered this the most was in region I, which is the Northeastern part of the United States, where there seemed to be a large number, if not an excess number, of surgeons in this particular category, in that we found that they were piggybacking on each other's surgery procedures.

And it was growing at geometric progressions. In examining across the country we saw the same kind of thing taking hold. It was a phenomenon developing in the field.

We also found that in certain parts of the country it was not allowed, but in other parts of the country it was allowed. This is part of the reason that we said we felt HCFA should make a firm policy statement as to exactly under what circumstances they should permit billing for assistant surgeons, at what rate, and under what circumstances they would not allow it, so that the carriers could make proper determinations.

Mr. WYDEN. One question. It is always good to see you, Mr. Kusserow. We appreciate your good work.

With respect to the second opinion rule, did you identify any specific problems with the second opinion rule? For example, did you find that patients such as the elderly get confused or find it hard to interpret the way it would work, or were there some areas where you did not save money? Did you find any evidence that it could be a rubberstamp kind of thing?

I would like to see any evidence of problems in the areas where you looked.

Mr. KUSSEROW. We found no evidence of a problem. This is a very well-studied area. In the formal submission of our testimony, we included ten different studies that had been performed on the subject. In none of those 10 studies had they encountered any problem with the mandatory second surgical opinion program.

We do have evidence in every program that we have looked at involving elderly beneficiaries that they tend to become more intimidated by bureaucratic processes than citizens at large.

Also, one of the difficulties encountered with the voluntary second surgical opinion program in Medicare has been the reluctance of this population to question their physician. There is also a feeling in many cases of helplessness with regard to being able to find the right physician to make a proper decision. In almost every case where we have encountered individual beneficiaries with this problem, they all said they would really welcome an opportunity to have somebody else tell them it was OK to have the second opinion as long as they were not the one to have to confront their doctor with it.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Nielson.

Mr. NIELSON. You indicate in your testimony that you feel you are ready to go on mandatory second opinions with HCFA's thinking it needs more study. Do you know what the cost would be of implementing the mandatory second opinion?

Mr. KUSSEROW. It would be a plus for the program. There would be savings, enormous savings that would come about. All of the evidence suggests that there would be great savings. Of 11 States that have mandatory second surgical opinion programs, none are losing money by having the program.

Mr. NIELSON. Are the savings because unnecessary surgical is not performed, or because you don't pay for that surgery under the mandatory system?

Mr. KUSSEROW. Under no circumstances do we recommend that we not allow the beneficiary to make decisions to go ahead if there

were differing opinions. We believe they should be able to make the decision.

What we have found is that there are fewer surgeries as a result of the mandatory second opinion, and therein is where you have—

Mr. NIELSON. There is savings because of fewer surgeries, and also because a second opinion does not pay for it.

Mr. KUSSEROW. If the beneficiary wants to go ahead with the surgery even though there is conflicting medical opinion, Medicare will still pay for it. What we are suggesting is that the beneficiaries at least be given the opportunity to have the best medical information available upon which to make a decision as to whether they want to have surgery. But if they have a second opinion that says the surgery is probably inadvisable, the beneficiary would still have the right to go ahead and Medicare would still pay for it.

Mr. NIELSON. You are suggesting three levels, aren't you—the original surgeon, the peer review, and then the second guy who is doing the second opinion? Aren't there three steps?

Mr. KUSSEROW. Not at all. What I would point out is that peer review would not get at a large part of this problem. Right now peer review does not extend to surgeries in an outpatient setting. In an inpatient setting, a peer review looks, in most cases, at the surgery billings after the surgery has been performed, not before. They also do not look—

Mr. NIELSON. They are after the fact?

Mr. KUSSEROW. In those cases where they do preadmission, it is only on a sampling method. Also there is the fact that the peer review physician does not examine the patient but only at the medical records that have been submitted for billing. Between those four points, we do not think that is an effective control against having unnecessary surgeries.

Mr. NIELSON. You agree with Congressman Kennelly? Is that a lot of surgeries done that is unnecessary; hysterectomies, particularly, prostate glands that is unnecessary?

Mr. KUSSEROW. I agree wholeheartedly with her position.

Mr. NIELSON. You think mandatory second opinions would cut a lot of that out?

Mr. KUSSEROW. There would be enormous savings and at the same time they would save lives.

Mr. NIELSON. You don't know how much the savings might be?

Mr. KUSSEROW. I would say for the Medicare Program again, it depends. A lot of it depends upon what elective surgical procedures you would want to put into the program. But the savings for Medicare alone could range between \$100 and \$150 million. And in Medicaid; across the board, it would be of a similar sum probably; but again the amount of savings would depend upon which procedures you would want to include. The more procedures you include, the more savings; the fewer procedures, the less savings.

Mr. NIELSON. You suggest every State should have a mandatory law. You say we should make it mandatory that the States pass a mandatory law. Why not just pass one nationally and take care of the problem rather than force the States to do it?

Mr. KUSSEROW. The Medicaid Program is a State-administered program, and the sovereignty of the State is something that is to be cherished.

Mr. NIELSON. But if you're going to force them to do something, mandate that they do a certain thing, aren't you essentially taking that away from them?

Mr. KUSSEROW. We believe that the State should make the decision to go ahead and do that, and we think we make a compelling case. It is difficult to order the States to do that when we have not done it for the Federal program.

Mr. NIELSON. States should be mandated to have a mandated program? It sounds like you should mandate it yourself and not go through the second step.

Mr. KUSSEROW. We can go ahead——

Mr. NIELSON. Just one step removed from forcing them directly.

Mr. KUSSEROW. We think it would be a good idea if you folks would do that.

Mr. NIELSON. That was my question. Why not do it and take the States out of it entirely?

Mr. KUSSEROW. We can do it as part of a State plan adjustment. There are lots of ways to get at it. One way would be to, in effect, pass legislation mandating it.

Mr. NIELSON. "\$300 million could be saved if all States were required to implement mandatory programs." That sounds to me like you might as well do it yourself and not leave the States the option.

Mr. KUSSEROW. This can be done through State plans approved by HCFA.

Mr. NIELSON. Not if they are required to do it. I guess it is a question of degree. I think the Federal Government ought to be careful saying that the States have to do something and then pretend that the States have the option and that the States are controlling the program. That is the point I am making.

Mr. WAXMAN. Thank you, Mr. Kusserow. We appreciate your testimony, and your views will be taken into consideration as we work on this legislation.

Mr. KUSSEROW. Thank you, Mr. Chairman.

Mr. WAXMAN. Let me call forward the next panel now and see if we can get in the first testimony before we have to break to vote. Clarice Jones, chairperson, Board of Directors, American Association of Retired Persons; Alan Spielman, director of government programs, Office of Government Relations, Blue Cross and Blue Shield Association; Mr. Bruce Fried, National Senior Citizens Law Center. If you would come forward at this time.

We are pleased to welcome you to our subcommittee hearing this afternoon. Your prepared statements will be made part of the record in full. What we would like to ask of you is to summarize in no more than 5 minutes.

Ms. Jones, let's start with you.

STATEMENTS OF CLARICE JONES, CHAIRMAN, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS; ALAN P. SPIELMAN, EXECUTIVE DIRECTOR OF GOVERNMENT RELATIONS, BLUE CROSS AND BLUE SHIELD ASSOCIATION; AND BRUCE M. FRIED, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER

Ms. JONES. Thank you, Mr. Chairman, for this opportunity to state the views of the American Association of Retired Persons on the Supplemental Medical Insurance Program commonly called part B of Medicare. My name is Clarice Jones. I am the chairman of the Board of Directors of AARP. I want to thank you, too, Mr. Chairman, and commend this committee for its leadership in the vital areas of health and environment.

I come from Michigan, and I am happy to see that you are considering water pollution also.

AARP believes that the part B program needs a general restructuring to meet the needs of our growing aged population. We believe, too, that savings alone is not an adequate basis upon which to restructure the part B system. Other criteria must be considered, too.

First, reform must correct the structural inefficiencies in the part B delivery system rather than merely shift costs to beneficiaries or other private payers. Second, proposals to change part B should improve the insurance character of the program rather than simply erode benefits for Medicare patients. And finally, any proposal to change Medicare must avoid sanctioning or encouraging the development of a multitiered system of care.

These principles are basic to restructuring the part B program. AARP believes that reforming physician reimbursement under part B is essential to rationalizing the system. AARP suggests a package of proposals to reform physician reimbursement, including a freeze on all services except primary care services, a national commission to review current policies, and recommend interim reforms, and the development and implementation of a national Medicare relative value system.

While intended to benefit the poor, the proposal of the Ways and Means Subcommittee provides no meaningful relief to lower-income elderly against the rising costs of health care. The out-of-pocket expense associated with Medicare deductibles, coinsurance, and uncovered services is the true catastrophic expense for the elderly poor.

Elderly households with income below \$10,000 spend seven times more of their income on these out-of-pocket expenses than they do on Medicare and private health insurance premiums. AARP sees no reason to introduce such a fundamental change into the Medicare Program that does so little to benefit the poor which it is intended to protect.

Second, the problem of rising part B premiums is not a premium problem but a problem of uncontrolled growth in part B expenditures. Varying the premium by income merely changes who pays the bills. It does nothing to correct current inadequacies in part B financing and coverage.

Third, by introducing a welfare-type notion, this provision establishes the precedent to launch Medicare down the path of a fully income-related program. One only has to witness recent ideas to increase taxation of Social Security cash benefits to realize that once the precedent is set, it becomes an easy vehicle to further erode the insurance protection for larger and larger numbers of older Americans.

Proposals to fundamentally change the part B program merit full public hearings. We urge Congress to oppose such changes without the opportunity for public discussion on their merits.

Over the past decade or so we have learned a great deal about how health care providers practice in this country. We know, for example, that the United States has the highest rate of surgery in the world and the highest ratio of surgeons to population in the world. Thus, it should not be surprising that the rate of elective surgery in the United States is increasing three to four times faster than the growth in the population. We know, too, that a great deal of the surgery being performed is inappropriate and unnecessary.

Though there have been many whose research elucidates this problem, the work of Dr. John Weinberg on small area variations in physician practices clearly shows that unnecessary surgery occurs on a regular basis. Moreover, his analysis of the DRG categories shows that there is a huge amount of practice variation within each DRG. If those variations are not appropriately reduced, policymakers will miss the most important opportunity for achieving meaningful savings in the Medicare Program.

AARP believes that an appropriate second surgical opinion program for Medicare and Medicaid could save hundreds of millions of dollars by reducing practice variations, improve the ability of peer review organizations to monitor quality and utilization, and provide an improved and more flexible benefit to Medicare and Medicaid beneficiaries.

[The prepared statement of Ms. Jones follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

Thank you, Mr. Chairman, for this opportunity to present the views of the American Association of Retired Persons (AARP) on The Supplementary Medical Insurance program (SMI), Medicare Part B. My name is Clarice Jones and I am Chairman of the Association's Board of Directors. AARP is the nation's largest membership organization of older citizens, representing more than 19 million older Americans.

AARP commends you and your committee for your leadership on the complex issue of Part B financing. We agree with you, Mr. Chairman, that Congress should begin now to bring about change in the Medicare Part B program for the following reasons:

1. The establishment of the DRG system for Medicare hospital payment will continue to shift care provision from the inpatient to outpatient setting. If nothing is done to reform Part B, the move towards outpatient care will exacerbate Part B's current spending problems. In addition, beneficiaries' out-of-pocket costs will significantly increase since coverage under Part B is less comprehensive than coverage under Part A.
2. Even with the enactment of last year's freeze on Medicare payments to physicians, Medicare Part B expenditures will continue to rise at an annual rate of increase of 16 percent. This rapid rate of increases places pressure on the federal budget, leading policymakers to look for program cuts based upon program savings alone rather than ways to create efficiencies in Part B which would benefit both providers and beneficiaries;

3. The current Medicare physician fee freeze expires this October. It is timely to consider what steps can be taken when the freeze expires to rectify well-documented problems and discrepancies in Medicare's current physician payment methods.

The Administration and Congress have been considering several proposals to reduce Part B expenditures by approximately \$2 to \$3 billion dollars over the next three years. AARP believes that additional criteria, rather than program savings alone, must be considered in evaluating any proposal to cut the Medicare program. First, any proposal to change Medicare must correct the structural inefficiencies in the health care system rather than merely shift costs to beneficiaries and/or private payers of health care. Second, any proposal to change Medicare should improve the insurance status of the program rather than simply erode benefits for the Medicare population. Finally, any proposal to change Medicare must prevent the development of a two-tier system of care. We urge Congress to look beyond immediate budget savings in the Medicare programs and adopt proposals which would reduce costs by creating a more efficient health care system.

AARP believes that Congress should begin now to implement long-term reform in the Medicare Part B program. Our testimony today will suggest several measures which produce both budget savings and greater efficiency in Part B financing and benefits.

Physician Reimbursement

It is now generally understood that Medicare's physician reimbursement system which is based upon what physicians customarily

charge each year (the CPR methodology) has led to over-inflation of physician expenditures by encouraging both price and volume increases. Between 1980 and 1982, Medicare expenditures for physician services rose by over 20 percent per year. While prices for physician services have outpaced general inflation, increasing intensity of services (the number of services per enrollee) accounted for nearly 40 percent of the growth in the Part B program over this time period. Moreover, the CPR methodology has generated numerous discrepancies and anomalies in physician payment such as:

- The gap in compensation for the use of technology and procedures over cognitive services;
- Differentials in reimbursement by specialty, place of service, and geographic location;
- The presence of payment incentives that discourage the treatment of the sickest and frailest segments of the population;
- The presence of payment incentives that encourage the use of expensive hospital care over less costly office-based care.

Last year Congress took an important first step towards addressing the complex problem of rising physician fees when it enacted the Medicare physician fee freeze. AARP believes that Congress should build upon this initiative and this year enact legislation which would serve as the basis for the institution of a more rational physician payment methodology. Failure to begin now is likely to mean year after year of arbitrary budget actions which will further erode the purposes of Medicare and its acceptability to beneficiaries and physicians alike.

AARP believes that no one payment methodology (DRGs, fee schedules, capitation, etc.) will be appropriate for all types of physician services. While AARP does not endorse at this time a particular mix of payment mechanisms, AARP would like to suggest a legislative package which would produce budget savings, begin to redress current inequities in Medicare physician payment, and move the current payment system towards long-term reform.

1. Rather than extend the current fee freeze to all physician services, apply a freeze to all Part B physician services except office, nursing home, and home visits. (Estimated savings: \$1.2 billion over three years).

Medicare reimbursement for physicians has undervalued office-based care compared to hospital-based care. A study by Hsaio and Stason found that office-based care has been paid at hourly rates of only one-fourth to one-fifth the hourly rate for surgical procedures. In 1982 Medicare's prevailing charge for hospital visits averaged 18-32 percent higher than for office visits. A higher rate of increase in Medicare fees for office, nursing home, and home visits would begin to redress this payment discrepancy between hospital-based care and office-based care. Moreover, a selective freeze targeting hospital-based care would be consistent with policy reforms already initiated by Congress to reduce unnecessary hospitalization, e.g., DRGs.

2. Establish a Physician Payment Evaluation Review Commission, modeled after PROPAC, to review current policies and make recommendations for further interim reforms in FY'87. Areas to target for such review could include:
 - o the identification of those procedures (e.g. surgical procedures) for which current charges may be overvalued and recommending reductions and the identification of those services (e.g. cognitive services) for which charges may be undervalued and recommending increases;
 - o the identification of unwarranted variations by geography, specialty, and place of service, and recommending steps to correct these variations;

- o the renewal of the participating physician program and recommending ways to expand it and increase the assignment rate by non-participating physicians;
 - o the review of variations in use of assistants at surgery and recommending procedures governing the use of these assistants; and
 - o the review of scheduled reports on options for Medicare physician payment such as the current study by the Office of Technology Assessment and the study on the feasibility of MDDRGs by the Health Care Financing Administration.
3. Following the TEFRA precedent which led to enactment of DRGs, require the Secretary to develop and submit to Congress a legislative proposal for the development and implementation, of a national Medicare relative value scale, beginning in 1987. Such a proposal would:
- o establish a national set of physician services and assign relative values or weights to those services; and
 - o develop a standard methodology for converting the relative values or weights to a prospectively-determined schedule of allowances.

The proposal should also include a timetable for transition to the new payment rates; a methodology for regular recalibration, and an allowance for geographic variations in cost-of-living.

An Income-Related Part B Premium

AARP opposes the Ways and Means Subcommittee proposal to income-relate the Part B premium. This proposal would establish a flat premium amount (approximately \$15 to \$16 a month) and then impose a new tax on Part B recipients with adjusted gross incomes above \$20,000.

While intended to benefit the poor, this proposal provides no meaningful relief to lower-income elderly against the rising cost of health care. The out-of-pocket expense associated with Medicare deductibles, coinsurance, and uncovered services is the true catastrophic expense for the elderly poor. Elderly households with income below \$10,000 spend seven times more of their income on these expenses than they do on Medicare and private health insurance premiums. AARP sees no reason to introduce such a fundamental change into the Medicare program that does so little to benefit the poor which it is intended to protect.

Second, the problem of rising Part B premiums is not a premium problem but a problem of uncontrolled growth in Part B expenditures. Varying the premium by income merely changes who pays the bill; it does nothing to correct current inadequacies in Part B financing and coverage.

Third, by introducing a welfare-type notion, this provision establishes the precedent to launch Medicare down the path of a fully "income-related" program. One only has to witness recent ideas to increase taxation of Social Security cash benefits to realize that once the precedent is set, it becomes an easy

vehicle to further erode the insurance protection for larger and larger numbers of older Americans. Taxation of Social Security cash benefits has already placed a heavy tax burden on middle and upper income older Americans. The Administration's tax reform proposal adds even more to the tax burden of these individuals. In light of these recent and proposed changes, AARP questions the fairness of further increases in the tax liability of older Americans.

Proposals to fundamentally change the Part B program merit full public hearings. We urge Congress to oppose such changes without the opportunity for public discussion on their merits.

Second Surgical Opinion Programs

Over the past decade or so we have learned a great deal about how health care providers practice in this country. We know, for example, that the United States has the highest rate of surgery in the world and the highest ratio of surgeons to population in the world. Thus, it should not be surprising that the rate of elective surgery in the United States is increasing 3-4 times faster than the growth in the population.

We know, too, that a great deal of the surgery being performed is inappropriate and unnecessary. Though there have been many whose research elucidates this problem, the work of Dr. John Wennberg on small area variations in physician practices clearly shows that unnecessary surgery occurs on a regular basis. Moreover, his analysis of the DRG categories shows that there is a huge amount of practice variation within each DRG. If those variations are not appropriately reduced, policymakers will miss

the most important opportunity for achieving meaningful savings in the Medicare program.

AARP believes that an appropriate second surgical opinion program (SSOP) for Medicare and Medicaid could save hundreds of millions of dollars by reducing practice variations, improve the ability of peer review organizations to monitor quality and utilization, and provide an improved and more flexible benefit to Medicare and Medicaid beneficiaries. The elements necessary for a workable and successful second opinion program are specified in H.R. 2807, introduced by Congresswoman Kennelly.

During a time of severe program cuts and huge federal deficits, a second surgical opinion program for Medicare and Medicaid offers a rare opportunity to save money, and improve the quality of health care at the same time.

Improve Part B Appeals

The Medicare Program has always permitted appeals from determinations made under Part A, but not for questions arising under the Part B supplemental insurance program. The original rationale for this discrepancy was that Part B claims did not involve substantial sums. Given such factors as: the increasing technological nature of medical care, the greater number of outpatient services, and the greater array of services available for treatment of a single illness, this is no longer true.

Medicare's failure to treat Part B appeals the same as Part A appeals is a glaring hole in the law. AARP supports Congressman Ron Wyden's legislation to correct this inequity. H.R. 2864, Administrative and Judicial Review of Medicare Part B Determinations, extends appellate rights to individuals denied benefits under Part B and allows a provider, if the beneficiary desires, to represent the beneficiary (provider representation of beneficiaries was permitted under Medicare for 16 years prior to 1984). H.R. 2864 also allows the aggregation of claims and increases the jurisdictional minimum for an administrative hearing to \$500, and the jurisdictional minimum for judicial review to \$1,000.

Clinical Laboratory Services

The Deficit Reduction Act of 1984 (DRA) established regional fee schedules for Medicare payment of clinical laboratory services. In addition, DRA mandated Medicare assignment for laboratory services provided by independent and hospital laboratories, but not for laboratory services provided directly by physicians.

AARP supports extension of mandatory assignment to those laboratory services provided directly by physicians. AARP sees no reason to have laboratory services mandatorily assigned when provided in certain settings but not in others. Continuation of this discrepancy subjects Medicare beneficiaries to unpredictable out-of-pocket expenses above Medicare's fee schedule amount when they receive laboratory tests in a physician's office. In 1984, unassigned charges (charges above Medicare's approved payment) associated with physician bills equaled \$2.4 billion, a 243% increase since 1977.

Vision Care

AARP supports H.R. 2342, The Medicare Vision Reform Act, which would allow doctors of optometry to become full providers under Medicare, subject to their state practice laws.

Medicare Part B currently covers certain eye and vision care services when provided by doctors of medicine or osteopathy, but not when these same services are provided by doctors of optometry. Consequently, Medicare beneficiaries who choose a doctor of optometry for their vision care, either because they have always gone to that provider or there are no doctors of medicine or osteopathy

readily accessible, must pay out-of-pocket for services which are essentially covered services. By correcting this payment discrepancy, H.R. 2342 would improve the availability and accessibility of vision care benefits under Medicare.

H.R. 2342 would also help to reduce beneficiaries' out-of-pocket costs by mandating assignment for ambulatory eye and vision care services provided under Medicare. Since this provision would mark the first time that professional services would be mandated under Part B, AARP urges close study of the impact of this change on the availability of eye practitioners who accept Medicare patients. Such study could also provide valuable information about the prospect of mandatory assignment for other Part B services and mechanisms for its implementation which prevent impeded access to care.

H.R. 2342 seeks to maintain budget neutrality by combining the charges of both optometrists and ophthalmologists into a common fee screen for purposes of determining the Medicare prevailing charge for services. AARP urges reexamination of this approach. To assure that no provider has his/her charge profile artificially raised or reduced over what it would otherwise have been, AARP recommends the development of separate fee screens for optometrists and ophthalmologists.

Mr. WAXMAN. Thank you, Ms. Jones, we will put the rest of the statement in the record.

We are going to take a recess now, and then we will return.

[Brief recess.]

Mr. WYDEN [presiding.] The subcommittee will come to order. Excuse the inconvenience. Chairman Waxman will be back very shortly, and let's proceed with you, Mr. Spielman.

STATEMENT OF ALAN P. SPIELMAN

Mr. SPIELMAN. Mr. Chairman, I appreciate this opportunity on behalf of the Blue Cross and Blue Shield Association to present our views on second opinions for elective surgery under Medicare, administrative issues regarding Medicare, and H.R. 2293, Mr. Wyden's proposed long-term care insurance bill. We will be submitting a detailed statement for the record.

Our private market experience with second opinion programs shows that use of voluntary programs is low despite extensive information, assistance, and incentives. The marketplace is increasingly demanding programs that require participation and do that by using specific financial penalties. Consequently, as you have heard, we have seen a tremendous growth in the development of mandatory programs by our plans. However, in our view, a mandatory second opinion program for Medicare should be demonstrated first and adopted only after full consideration of the demonstration results.

We take this position because we believe that there are some notable differences between the Medicare program and private group health benefits particularly in the following areas: Size and accessibility of the Medicare population and the need for individual communications and assistance. For example, in the private market, employers perform a major role in communicating closely with employees on the complexities of these programs.

In addition the situations of the institutionalized elderly must be taken into account.

Next, the medical needs of the population might be different.

Finally, administrative complexities must be considered; for example, the extent to which part A and part B interface might be needed.

If, however, you decide not to demonstrate first but to go ahead with H.R. 2807 or similar legislation, we suggest that you consider the following: First, the uncertainty of cost-savings estimates. The lack of experience with a mandatory program for Medicare and other factors make it difficult to predict cost savings, and in addition, allowing a waiver of the penalty in extraordinary circumstances, as we believe is necessary, will reduce savings. As an example, one of our plans found it necessary to waive over 50 percent of the penalties because the subscriber happened to be outside of the 50-mile radius of the referral physician, and for other valid reasons.

Second, we believe the Secretary should have flexibility to use part B carriers, intermediaries, and other private entities to operate the referral center. H.R. 2807 assigns this function to the PRO's and enables the Secretary to use other entities only if there is no

PRO available. We think that cost effectiveness and program experience should be the criteria for selecting these entities.

The third issue we ask that you consider is the size of the financial penalty. We suggest that you consider alternatives to denying the full amount of Medicare payment where a second opinion was not obtained. In our private business, plans typically impose a co-payment of between 20 and 50 percent, and often there is a maximum on the out-of-pocket liability.

Regardless of any move to a mandatory second opinion program, as you know, the Medicare program already is extremely complex. That complexity is managed on a day-to-day basis by carrier and intermediary contractors who administer the program. We believe that it is important that this subcommittee be aware that the administrative structure of Medicare is facing a severe funding shortfall that will erode the ability of contractors to control program payments, to implement Medicare changes, and to communicate and assist beneficiaries and providers.

Moreover, significant delays in payment cycles resulting from any insufficiency of claims payment funding could work to discourage certain physicians from accepting assignment.

We have shared these concerns with the Appropriations Committee which has jurisdiction. However, we would like to work closely with this committee in considering the effects of any new legislation on Medicare administration. We also would appreciate your support in reinforcing the policy that severe restrictions, in the resources devoted to program administration are pennywise and pound-foolish.

We are pleased to see Congressman Wyden and other Members of Congress taking an interest in the need for the long-term care insurance product. Our Association and several plans are actively engaged in a long-term care product development effort. We believe that there is a role for the private sector in financing long-term care. However, the exact nature of that role is only beginning to develop. We are concerned about the possible effects of Federal standards on the development of innovative products for this marketplace. We hope to work with Congressman Wyden and this subcommittee on approaches to facilitate the development of appropriate long-term care products that are responsive to market needs.

Thank you, Mr. Chairman.

[Mr. Speilman's prepared statement follows:]

**TESTIMONY
OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION**

Mr. Chairman and members of the subcommittee, I am Alan P. Spielman, Executive Director of Government Relations for the Blue Cross and Blue Shield Association. Our Association and member Plans perform Medicare intermediary and carrier functions under contract with the Health Care Financing Administration. In addition, Blue Cross and Blue Shield Plans are the source of private supplementary coverage for 9 1/2 million Medicare beneficiaries. We appreciate this opportunity to share our views on second opinions for elective surgery under Medicare and H.R. 2807, the Medicare and Medicaid Second Opinion Act of 1985; administrative considerations regarding Medicare changes and ongoing activities; and H.R. 2293, Representative Wyden's proposed long term care insurance bill. We would also like to address a number of Medicare Part B budget proposals.

SECOND OPINIONS

H.R. 2807, introduced by Representative Kennelly, would establish a mandatory second opinion program for Medicare. Under the bill, the 20% Part B coinsurance would not apply to the reasonable charges for the second opinion. If a second opinion were not obtained, no Medicare payment would be made for the surgery. The beneficiary could request referral to another physician through a second opinion referral center, which would be a Peer Review Organization (PRO), unless no PRO were available to perform this function. Exceptions to the second opinion requirement would be permitted if delay would be a risk, if no appropriate referral physician were available to render the second opinion, or if the beneficiary were enrolled in an HMO or Competitive Medical Plan.

Second opinion programs are generally classified as being either mandatory in that health benefits are reduced if the patient does not obtain a second opinion, or voluntary. Our private sector experience shows that use of voluntary programs is low, even with extensive information, assistance and financial incentives. The marketplace is increasingly demanding programs with specific financial penalties for noncompliance. Consequently, we have seen tremendous growth in the development of mandatory programs by our Plans. In 1982, only 17 Plans had mandatory programs; 56 Plans now have such programs.

In our view, a mandatory second opinion program for Medicare should be demonstrated first, and adopted only after full consideration of the demonstration results. We take this position because we believe there are some notable differences between the Medicare program and private group health benefits, particularly in the following areas:

- o Size and accessibility of the Medicare population and need for individual communications and assistance. For example, in the private sector, employers perform a major role in communicating closely with their employees regarding these programs. Compared to employed groups of hundreds or at most thousands of employees whose employers are sources of information about program operations, communicating the program details to the Medicare population of millions presents a formidable administrative task. Effective operation of referral centers would be critical to success of the program and at the same time difficult to accomplish.
- o Medical needs of the population. The efficacy of mandatory second opinions for certain specific surgical procedures is not clear for Medicare beneficiaries.

In addition, the list of surgical procedures for which second opinions can be applied with the best return in operations appropriately avoided and money saved may not be the same in the over 65 Medicare population as it has been in the insured general population.

- o Administrative complexity. Data from Parts A and B may need coordination, substantial beneficiary education would be necessary, and Medicare carriers would need claims-processing computer system changes and enhanced efforts on beneficiary inquiries.

If, however, you decide not to demonstrate first, we suggest that you consider the following:

1. Uncertainty of cost saving estimates. The lack of experience with a mandated program for Medicare and the varying results and design limitations of existing studies make it difficult to predict cost savings with a high degree of certainty. In addition, allowing a waiver of the penalty in extraordinary circumstances, as we believe is necessary, would reduce savings. For example, one of our Plans waives the penalty in over 50 percent of cases because the subscriber is not within 50 miles of a referral physician, as often occurs in rural areas, or for other valid reasons.
2. The need for administrative flexibility. Most Medicare Part B carriers now provide beneficiaries with the names of surgical consultants who are willing to furnish second opinions in the existing voluntary program. Also, as indicated previously, Blue Cross and Blue Shield Plans have extensive experience with mandatory second opinion programs in the private market.

We believe the Secretary should have the flexibility to use Part B carriers, intermediaries, and other private entities to operate the referral center.

H.R. 2807 assigns this function to the PROs and enables the Secretary to use other entities only if there is no PRO available. We think that cost effectiveness and program experience should be the criteria for selecting the referral entity.

3. The size of the financial penalty. We suggest you consider alternatives to denying the full Medicare payment where a second opinion was not obtained. In our private business, Plans typically impose a copayment of 20 to 50 percent subject often to a maximum out-of-pocket liability.

MEDICARE ADMINISTRATION

Regardless of any move to a mandatory second opinion program, the Medicare program already is extremely complex. This complexity is managed on a day-to-day basis by carrier and intermediary contractors who administer the program. We believe it is important that the subcommittee be aware that the administrative structure of Medicare is facing a severe funding shortfall. This shortfall will erode the ability of contractors to control program payments, to implement Medicare changes, and to communicate and assist beneficiaries and providers. Moreover, significant delays in the payment cycles resulting from insufficient funding for claims processing could discourage certain physicians from accepting assignment.

We have shared these concerns with the Appropriations Committee, which has jurisdiction over this aspect of Medicare. However, we would like to work closely with this subcommittee in evaluating the effects of any new legislation on Medicare administration. In addition, we would appreciate this subcommittee's support in reinforcing the policy that severe restrictions in the resources devoted to program administration are "penny-wise and pound-foolish."

H.R. 2293

We are pleased to see Congressman Wyden and other Members of Congress taking an interest in the need for long term care insurance products. Our Association and several Plans are actively engaged in a long term care product development effort. We believe that there is a role for the private sector in financing long term care. However, the exact nature of that role is only beginning to develop. Consequently, we are concerned about the possible effects of federal standards on the development of innovative and affordable products for this marketplace.

We hope to work with Congressman Wyden and this subcommittee on approaches to facilitate the development of appropriate long term care products responsive to market needs.

MEDICARE PART B BUDGET ISSUES

Among the Administration's budget proposals affecting Part B are proposals to increase the Part B premium, index the Part B deductible, continue the physician fee freeze, and expand the "working aged" provision. Among other items, the Ways and Means Subcommittee on Health has recently approved a continuation of the physician fee freeze with increases for "participating" physicians, and a prohibition on payment for assistant surgeons' fees for routine cataract operations. In addition, that subcommittee has approved a provision that would require the Secretary to evaluate the feasibility of extending PRO prior approval activities to outpatient and ambulatory settings. Our comments on these proposals are as follows:

Part B Premium and Deductible. If Congress decides that some sort of increase in Part B cost sharing is necessary to help reduce the deficit, we believe that the most equitable approach would be through Part B premium adjustments. Premium adjustments spread the cost burden among all beneficiaries, rather than targeting only those beneficiaries who have need of services. The proposed increase in the Part B deductible would hit beneficiaries when they are ill and can least afford out-of-pocket costs. Beneficiaries now share significantly in the costs of Part B services — through the premium, the deductible, and the coinsurance — and some beneficiaries cannot afford even this level of cost sharing. At some point, Congress should consider whether lower-income beneficiaries need additional protection.

Physician Fee Freeze. We have opposed a simple extension of the physician fee freeze because of the negative effect it would have on those physicians who have agreed to participate — that is, to accept assignment on Medicare claims in all cases.

We know from experience that participating physician programs offer the best promise for simultaneously controlling physician payments and protecting patients from unexpected and excessive financial liabilities. The vast majority of Blue Cross and Blue Shield Plans have physician participation programs under which participating physicians agree to accept Plan payments as full reimbursement for services delivered to their subscribers. As noted in our April 26th testimony before this Committee, we believe that the new Medicare participating physician program appears to be responsible for increasing the assignment rate to 69% of all physician and supplier claims and promises substantial beneficiary protection. All of those responsible for this program are to be commended for this achievement. We encourage you to make all efforts to retain and increase the viability of the participating physician program.

Many physicians, however, entered into Medicare participating agreements with the promise that they would receive specific future financial consideration because of their participation. We strongly urge you not to break that faith but to offer every feasible incentive to participate, including a financial incentive, such as that recently approved by the Ways and Means Health Subcommittee.

We believe that the participating physician program and the claim-by-claim assignment option for other physicians should be continued for an additional period before any decision is made about eliminating it. We believe, however, that the Medicare program should soon eliminate the selective claim-by-claim option for physicians, and provide maximum incentives for physician participation. We believe that this policy offers the greatest potential to increase the Medicare assignment rate because it takes full advantage of the changes that are occurring in the market for physicians' services. As the supply of physicians and beneficiary understanding of this simpler system increase, the marketing advantages of becoming a Medicare participating physician would likewise increase. Finally, this policy would better position Medicare to experiment with and ultimately adopt some of the innovative cost containment approaches now being used by the private sector, such as preferred provider organizations and selective contracting. We recognize that no solution will be perfect, but believe that a strong participation policy will, on balance, be most advantageous to the program and its beneficiaries.

Assistant Surgeon's Fees. We support the proposal to require the Secretary of HHS to establish national guidelines to prohibit Medicare payment for assistant surgeons' fees for routine cataract surgery. Based on their reviews of local practices and circumstances, a substantial number of Blue Cross and Blue Shield

Plans in their private business have found that the use of an assistant surgeon for routine cataract operations cannot be justified on the basis of medical necessity. We estimate that about one-third of our Plans routinely deny payment for an assistant for this procedure.

Expansion of the Working Aged Provision. Expansion of the so-called "working aged" provision to beneficiaries and their spouses aged 70 and over would be an extension of the working aged provisions approved in TEFRA and DEFRA. This proposal would impose greater liability on employers and their health benefits carriers. If Congress decides to reduce the federal government's responsibility for financing health care for the elderly by adopting this proposal, we urge that adequate lead time be provided to minimize disruption and confusion. For example, two government agencies have jurisdiction on this issue, and they previously promulgated conflicting regulations that were not issued until well after the original law's effective date. We are concerned that the employers of beneficiaries will have an added financial responsibility and another unexpected administrative burden as a result of the current proposal, and that beneficiary, employer, carrier and intermediary confusion will result if the implementation period is too short.

PRO Review of Part B Services. We recommend that any evaluation of the feasibility of extending PRO prior approval activities to outpatient and ambulatory settings also consider the extent to which Part B carriers, or private entities other than PROs, might perform this function more efficiently and effectively than PROs. Medicare carriers have extensive experience in medical review of Part B services and a growing number of private payers have prior approval programs for outpatient and ambulatory care.

SUMMARY

We would like to commend the subcommittee for examining proposals on second surgical opinions, long term care insurance, and Part B budget issues. In summary, we ask that you consider the following points:

- o A mandatory second opinion program for Medicare should be demonstrated first, and adopted only after full consideration of the demonstration results.
- o The administrative structure of Medicare is facing a severe funding shortfall that will erode the ability of Medicare contractors to control program payments, implement policy changes, and assist beneficiaries and providers. Severe restrictions in resources devoted to program administration would be "penny-wise and pound-foolish."
- o There is a role for the private sector in financing long term care, but the exact nature of that role is only beginning to develop. The development of innovative and affordable products could be impeded by restrictive standards.
- o If Congress determines that beneficiaries should bear a greater share of Medicare costs, increases in premiums are preferable to increases in deductibles or copayments.
- o In considering the proposals to extend the physician fee freeze under Part B of Medicare, all efforts should be made to maintain or enhance the incentives for physicians to become "participating physicians."
- o Further expansion of the provision making Medicare the secondary payer for "working aged" beneficiaries and spouses should be accompanied by adequate lead time and increased efforts to assure that all affected parties have a clear understanding of any changes.
- o Any evaluation of the feasibility of extending PRO prior approval activities to outpatient and ambulatory settings should also consider the extent to which Part B carriers, or private entities other than PROs, might perform this function more efficiently and effectively than PROs.

We would be pleased to work with the subcommittee to address these issues.

Mr. WYDEN. Mr. Spielman, thank you. Certainly, I appreciate your comment and am very anxious to work with you with respect to the long-term care area and come up with something voluntary. We look forward to some questions.

Mr. Fried.

STATEMENT OF BRUCE M. FRIED

Mr. FRIED. Thank you, Mr. Chairman. My name is Bruce Fried, attorney with the National Senior Citizens Law Center in Washington, DC. I would like to thank Chairman Waxman for the invitation to appear before the committee today to specifically address the provisions of H.R. 2864, Congressman Wyden's bill addressing the need for improved appeals processes under Medicare. We appreciate the invitation.

I have told Mr. Wyden this personally, and I want to say it publicly. We applaud you for having the courage and initiative to introduce the legislation that my colleagues and I feel is long overdue.

I would like to address why we think that the time is ripe for the issues to be addressed. As the committee knows, there are essentially two issues in H.R. 2864. The first would bring the part B appeals process up to date. It would revise the part B appeals process essentially for the first time since the program was enacted 20 years ago.

The second portion would make it clear that the beneficiary may choose whoever he or she wishes to represent him or her without concern whether that beneficiary is a provider of services.

It would be instructive to advise the committee in terms of the appeals system. If you are a part A claimant and appealing a part A denial, the system permits an appeal to an administrative law judge if there is at least \$100 in dispute. If the individual is dissatisfied with the ALJ's decision and there is at least \$1,000 in dispute, then the matter can be reviewed by a Federal court.

Interestingly, there is a small number of part B beneficiaries who receive that same quality of due process; that is, those part B beneficiaries participating in health maintenance organizations. For the vast majority of other part B beneficiaries, the process is essentially that if there is \$100 in dispute and there is an issue to be appealed, the appeal is to a hearing officer that is essentially representative of the carrier that initially processed the claim, regardless of the amount in dispute. Regardless of the decision of the hearing officer, that is the end of the road. There is no appeal to an administrative law judge, there is no way that one can go to Federal court.

This process actually did make a bit of sense historically—20 years ago Congress rightly recognized that at that time part B was going to be the smallest portion of Medicare pie. The issues were going to be small. The amounts of controversy were going to be small. And the issues were going to be much simpler.

Of course, we face a much different situation now. Congressman Wyden alluded to the impact of the prospective payment system. The ripple effect of the PPS goes far beyond part A, resulting in substantial numbers of what had been part A cases now being done

as part B cases on an outpatient basis. These are enormously complex cases, cases in which there are substantial sums of money at issue.

Indeed, the most recent report from the carriers indicates that the average amount in dispute for a part B case is in excess of \$1,000. So you can see that these are not small sums that we are talking about.

The problems that present themselves with the carrier system are systemic problems that I want to hasten to add do not relate to the carriers themselves or to the individuals that are hearing officers. In the vast majority of cases, the cases are processed more than adequately and result in good decisions. We are talking about a system with 175 million claims considered each year, with a mountain of paperwork that makes all of us scratch our head and wonder how it functions at all.

The simple fact of the matter is that there are going to be mistakes made. It is a human endeavor, and God knows that there is not a human born that has not made a mistake. And frankly, for my client who runs afoul of the system who has the mistake made to them, it simply does not make sense for them not to be able to have due process and some greater level of fairness afforded to them.

Congressman Wyden's proposal essentially adopts a system similar to that that is already available for part A. The main difference is that there has to be at least \$500 in dispute in order for there to be an ALJ hearing. The bill keeps the existing fair hearing process where there are lower levels of money at issue. Where the sums start to get into a more significant range, a greater degree of due process is afforded with an appeal to an ALJ, and as with the other portions of the system, if there is \$1,000 in dispute, the individual would be able to seek judicial review.

I want to underline "review." This would not be a full-blown jury case. It would simply be the court reviewing the record to determine whether the Secretary's decision is supported by substantial evidence.

The second aspect of the proposal relates to provider representation for 18 years a provider—a beneficiary could select any individual or entity that he or she wanted to represent them.

My statement is in the record.

[The prepared statement of Mr. Fried follows:]

TESTIMONY
OF
BRUCE M. FRIED
OF THE
NATIONAL SENIOR CITIZENS LAW CENTER

My name is Bruce Fried. I am an attorney at the National Senior Citizens Law Center here in Washington, D.C. I want to express my thanks to Chairman Waxman for inviting me to appear before the Committee today. I am also here on behalf of several clients who have requested our assistance in addressing issues that limit the fairness of the Medicare program. There are two issues in particular that I want to discuss with the committee: the first is the very limited rights of appeal provided to beneficiaries under Part B of the Medicare program, the second in a recent government policy change that denies Part A beneficiaries the right to choose as their representative the organization or individual that could be their best advocate.

Let me say at the outset that both of these matters are addressed in HR 2864, the Fair Medicare Appeals Act of 1985, which Representative Ron Wyden has introduced. If enacted HR 2864 will provide an effective remedy for these problems which limit fundamental fairness in the Medicare program.

APPEALS OF PART B CLAIMS DENIALS

By way of background, Medicare's Part B program, formally the Supplemental Medical Insurance program, provides coverage for doctor's services (inpatient and outpatient), medical equipment, outpatient hospital services, rural health clinic services, ambulance services,

physical and occupational therapy and speech pathology. Generally, coverage is provided for care or services that are medically necessary. Medicare pays for 80% of what it determines to be the "reasonable" charge after the beneficiary has met the annual deductible (\$75 for 1985). The beneficiary must also pay a 20% copayment for each claim, plus the difference between the "reasonable charge" and the actual charge, unless the provider or physician accepts assignment.

The current system for appealing Part B claims decisions, where a claim is denied in whole or in part, is unchanged since the Medicare program was enacted in 1965. Where a carrier (an insurance company that processes part B claims) has denied a claim in whole or in part, and where there is at least \$100 in dispute¹, the beneficiary may request a hearing before a "Part B hearing officer." This officer is an employee of the the carrier whose decision he or she is reviewing. Regardless of the amount in controversy, and regardless of the hearing officers decision, the beneficiary has no right to have the matter reviewed by a federal court.

This limited review process, while outdated, was justified in its historical context. At the time of the

¹ Disputes of less than \$100 are subject to a carrier paper review.

original enactment of the Medicare program, the Congress expected that the payments made under the supplemental Part B program would be smaller than under the primary Part A program. Thus, it was the "carriers, not the Secretary, [who] would review beneficiary complaints regarding the amount of benefits, and the bill [did] not provide for judicial review of a determination concerning the amount of benefits under part B where claims [would] probably be for substantially smaller amounts than under part A." S Rep No. 404, 89th Cong, 1st Sess, 54-55 (1965).

The limited appeal rights available under part B was reiterated in 1972 when Senator Bennett offered an amendment to clarify the unavailability of judicial review. As the Senator said, "The situations in which medicare [part B] decisions are appealable to the courts were intended in the original law to be greatly restricted in order to avoid overloading the courts with quite minor matters...The proposed amendment would merely clarify the original intent of the law and prevent the overloading of the courts with trivial matters because the intent is considered unclear." 118 Cong Rec 33992 (1972).

In 1982 the Supreme Court considered the limited appeal rights under part B in United States v Erika, Inc., 456 US 201, 102 S Ct 1650. The Court reviewed the legislative history and found it clear that judicial review of part B claims decisions was precluded by Congress.

The Supreme Court made it clear to all that if judicial review were to be afforded in part B cases it would be the Congress that must act.

The part B hearing officer system was reviewed in the case of McClure v Harris, 503 F.Supp. 409 (N.D.Ca.1980). In that case, the district court found several deficiencies with the Part B hearing system. For instance, the court found that the hearing officers, as a class, have their impartiality compromised by virtue of both prior involvement and pecuniary interest. They have been vicariously involved because they are appointed by and serve at the will of the carrier which has not only participated in the prior stages of each case, but has twice denied the claims (through internal reviews) which are the subject of the hearing. Officers could only rule in the beneficiaries' favor by directly overturning the carriers' decision. This problem was underscored when the court noted that most of the officers were former or current employees of the carrier. Such prior involvement raised a specter of partiality akin to that present where judges routinely disqualify themselves from hearing matters in which their former associates are involved. This risk of partiality was particularly of concern since the officers incomes were entirely dependent upon the carriers decisions regarding whether, and how often, to call upon their services. For these and other reasons the district court found the Part B hearing officers

system to be violative of the beneficiaries' due process rights.

Subsequently, the decision in McClure v Harris was overturned by the Supreme Court in Schweiker v McClure, 456 US 188, 102 S Ct 1665 (1982). Essentially, the Court found that the record did not support the district court's finding. From the Supreme Courts view, the plaintiffs had failed to prove their case.

PART B APPEALS IN A MODERN CONTEXT

Without questioning the systemic partiality of the Part B hearing officer system of review, it is unquestionable that the Medicare Part B system has experienced a change as revolutionary as that experienced under part A by virtue of the Prospective Payment System (PPS). The PPS was enacted to revolutionize the Medicare reimbursement mechanism for hospital inpatient services under Part A.

Under PPS, Hospitals are given an incentive to perform more efficiently and, thus, where possible are performing many services on an outpatient basis under part B. Many services once performed on an inpatient basis are also now being done in physicians offices. Indeed, the entire range of services being performed under part B are far more complex and costly then just a few years ago. And,

of course, a physicians' services, whether performed on an inpatient or outpatient basis, are covered under Part B.

Simply stated, Part B is a far more complex program, involving far larger sums of money, than it was twenty or ten or even five years ago. It can no longer be said that part B disputes are all trivial or inconsequential, and thus do no warrant a more complete appeals process.

The Medicare program for all its computers, policy documents, and systems is ultimately a human endeavor. Perhaps the largest such endeavor ever undertaken by man. In 1984 there were more than 175,000,000 Part B claims filed. Such a volume of filings, papers, decisions, internal reviews, and hearing officer decisions, dictates that inevitably there will be some cases in which a decision will be made that is simply wrong. For the beneficiary who wants to obtain court review of the wrong decision it is simply too bad.

At this point it would be instructive to consider several actual cases which serve to highlight the kinds of part B cases which would benefit from an improved administrative hearing and judicial review system.

Example 1: Oregon

Mrs. A, a Social Security disability recipient, was informed by the insurance carrier that she would not be reimbursed for those back treatments that exceeded the number of visits allowed by the insurance carrier's guidelines. The beneficiary appealed the denial of some of

her visits and the carrier's hearing officer ruled in her favor. So far so good.

However, the carrier continued to deny Mrs. A's benefits. Once again, Mrs. A appealed the carrier's denial for her back treatments. The same hearing officer heard this second appeal. Mrs. A and her doctor testified that if anything her condition was worse than in the first case. At the close of the case the hearing officer said he MIGHT ask for a consultants opinion. Mrs. A asked for a chance to review such an opinion and comment on it, which the officer agreed to.

Subsequently, the hearing officer denied Mrs. A's claim entirely. The basis of the denial was a consultant's opinion that Mrs. A never had a chance to see or comment on. Mrs. A asked the officer to reopen the case so she could review and comment on the consultant's opinion. The officer refused because "based on the consultant's opinion...additional review by [you or your doctor] would not be indicated." This clearly arbitrary decision can not be subjected to judicial review.

Example 2: California

In 1982, Mrs. B, an elderly claimant, underwent neurosurgery to relieve chronic headaches which she had suffered from for many years. The surgeon's bill for \$6,000 was submitted to the carrier for payment. The carrier subsequently approved \$1,510.80 for payment to the surgeon. There was no explanation given as to how this figure was reached. A request for reconsideration was made, and this time the carrier increased the approved amount to \$1,888.90. The carrier explained only that the original determination was incorrect. So far the process had taken almost a year.

Mrs. B requested a hearing on her claim. At the hearing, almost a year and a half from the date of the surgery, Mrs. B asked that the basis of Medicare's determination be explained, and that the hearing be continued so that she could review the explanation and prepare her response. The hearing officer denied her requests.

Interestingly, the hearing officer had been in that position for only six months. Previously, he had been a claims examiner for the same carrier for 24 years.

The hearing officer advised Mrs. B that prior to the hearing he had consulted the carriers medical consultant, whom he had worked with for many years. The consultant, a

general surgeon with no neurosurgery experience, had made the carrier's determination, and that was good enough for the officer. The consulting physician made no written report and did not appear at the hearing. When Mrs. B asked to question the medical consultant, the hearing officer told her such questioning was not part of a hearing.

This decision, involving a substantial amount of money, was made without explaining the basis of the decision, denied the claimant a chance to question the decision maker, was made using ex parte communication, and precluded the beneficiary from being able to present her side of the case. Of course, the claimant has no right to have the courts review this less than fair decision.

Example 3: New York

Mrs. C. is wholly dependent on a respirator to sustain her breathing. Without a standby respirator, her life is in danger should the primary respirator breakdown. Notwithstanding this clear example of medically necessary equipment, the carrier denied coverage based on a policy document from HHS that had never been officially published. The requested reconsideration was performed by the same individual that made the initial denial.

A hearing was requested. Mrs. C, through her attorney, requested an opportunity to question the carrier's medical consultant. This was denied by the officer in writing. Similarly, the attorney asked for the opportunity to examine other policy makers and documents that had weighed on this claim and that request was also denied.

Only by avoiding the hearing officer, and seeking direct intervention from the HCFA administrator's office, was Mrs. C able to have her stand-by respirator covered.

Example 4: New York

Over the period of a year, Mrs. D required four identical treatments from the same physician for vascular problems in her legs. The physician's bills were \$750 for each treatment. For each treatment the carrier initially approved no more than \$100. After reconsideration, two of the treatments were approved for \$500, while two were not revised. At the hearing on one of the claims that was not increased, the hearing officer refused to alter the approved amount. When Mrs. D objected and advised that two other identical claims had been paid at a higher level, the hearing officer threatened to reopen those cases and reduce their approved amount if Mrs. D persisted in her objections.

Despite the fact the the same procedure, by the same physician, on the same patient, in the same year were paid at different rates, there is no way for Mrs. D to have the hearing officers decision reviewed.

Example 5: Maryland

The claimant, who suffered from a stroke and severe arthritis, was prescribed an electric wheel chair. The carrier approved only half the cost of the chair. At the hearing the officer questioned whether the claimant needed an electric wheel chair at all, though that was not the issue before the officer. As it turned out, once again ex parte communications had occurred.

While the question of medical necessity was ultimately resolved, the amount of reimbursement never was. Despite the claimant's producing evidence showing that electric wheel chairs are reimbursed at a higher level by several other carriers, the hearing officer refused to consider that evidence.

In each of these cases, the beneficiary sought review of claims denials involving substantial amounts of money. In each instance, these matters would likely have been more fairly resolved had they been considered by an ALJ. In any case, the right to have these matters reviewed by a court, to assure compliance with the Medicare statute, remains essential.

Incredible as it may be, Medicare Part B beneficiaries are the only health insureds in the country with no right to have a court enforce the terms of their health insurance.

PROVIDING IMPROVED ADMINISTRATIVE HEARINGS AND
JUDICIAL REVIEW TO PART B BENEFICIARIES

Rep. Wyden's bill will provide part B beneficiaries with appeal rights similar to those now available to part A beneficiaries and those Part B beneficiaries participating in Health Maintenance Organizations. The bill provides that where there is at least \$500 in dispute² the beneficiary will be entitled to a hearing by an Administrative Law Judge (under Part A there need only be \$100 in dispute). The bill provides that where there is at least \$1,000 in dispute following an ALJ hearing the beneficiary may seek review from a federal district court (the same system of judicial review is currently available under part A). The bill will permit the beneficiary to aggregate similar claims or those that address the same issues of law and fact in order to reach the jurisdictional amounts.

While Rep. Wyden's bill will significantly improve the fairness of the Medicare system, it is expected to have only a small fiscal impact.

² Where the amount in dispute is at least \$100 and less than \$500 the matter would be considered by the part B hearing officer.

For 1982, 175 million claims were submitted under Part B. Approximately 20,000 of those claims were appealed to a carrier hearing officer. Available statistical information shows that approximately 50%, or 10,000, of those claims had amounts in dispute of \$500 or more, and that 20-25%, or at most 5,000, of those claims had amounts in dispute of \$1,000 or more.

Under Mr. Wyden's proposal half of the Part B claims appealed, those with less than \$500 in dispute, would be considered under the existing part B hearing officer system. The other half, those involving larger sums, would be referred to ALJs. Since the ALJs will be substituted for the hearing officers there would not be a duplication of cost. The savings realized by having half as many Part B hearing officer hearings would be used to pay for the ALJ hearing. An analysis of ALJ hearing and hearing officer hearing cost data shows that a Part B hearing officer hearing and an ALJ hearing have approximately the same cost. Even if the direct cost of an ALJ hearing is slightly more, the savings realized by having a more rational, more certain claims process will greatly off-set any additional cost.

The impact of judicial review will, likewise, be relatively slight. Of the 5,000 appealed cases that would meet the \$1,000 jurisdictional limit, many of them would be disposed of by the ALJ. For the five month period October

1984 through February 1985, there were 87,391 decisions³ rendered by ALJs for all Social Security Act programs.⁴ Of those, 50,744 or 58% resulted in favorable decisions for the claimant, while 36,647, or 42%, of the cases were affirmed.⁵

Assuming those statistics reflect the outcome of Part B appeals to ALJs, then only 2,100 Part B cases would have been appealed to and ALJ, would be over the \$1,000 threshold for judicial review, and would not have resulted in a favorable decision by the ALJ. Even those 2,100 cases would not all result in court cases. Approximately 87,952 cases are affirmed (favorable to the agency) annually for all SSA cases. Of that number 29,985 or 34% were appealed to a Federal court in 1984.⁶

Assuming the same percentage of Part B ALJ cases are appealed only 714 Part B cases would reach the federal Courts annually.

³ Office of Hearing and Appeals, Social Security Administration, Key Workload Indicators, February, 1985.

⁴ Retirement and survivors insurance, Disabled widows insurance, Disability insurance, Part A Medicare Benefits, Black Lung benefits, SSI, and concurrent Title II and Title XVI

⁵ Office of Hearing and Appeals, supra.

⁶ Annual Report of the Director of the Administrative Office of the United States Courts, 1984.

Of course, these 714 cases would be among the most straight forward matters that reach the federal courts. Since they would only involve a review of the ALJs decision to be sure that the law was correctly applied, there would be no need for jury trials, evidentiary hearings or other elaborate fact finding proceedings. Indeed, these would be exactly the type of case that federal magistrates would handle, thus further avoiding significant impact on the federal courts.

The average cost of a non-jury civil matter is \$1,900. These figure represents all civil cases heard by a federal judge without a jury, including matters with questions of fact. Since there would be no questions of fact in Part B reviews, and since most of these cases will be heard by magistrates, the cost per case would be less than the average of \$1,900. Even accepting the \$1,900 figure, the cost for 714 Part B judicial review cases would be \$1.3 million.

Given the comparatively inconsequential cost of providing these improved fairness procedures, there is simply no reason to continue to deny part B beneficiaries with significant amounts in dispute access to high quality ALJ hearings and judicial review.

ASSURING PART A BENEFICIARIES THE RIGHT TO THE
REPRESENTATIVE OF THEIR CHOICE.

ASSURING BENEFICIARIES THE RIGHT TO THE
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As anyone who has examined the Medicare system is aware, it is as complex a system and mindboggling a process as man could create. There is little doubt that virtually all beneficiaries confronting a Medicare dispute require assistance in order to most effectively pursue their rights or interests. Among the most effective representatives of beneficiaries have been providers or suppliers. In most instances there is simply no other entity or individual that understands the Medicare program or the beneficiaries particular medical needs as well as the provider of the care.

In 1984, the administration changed 18 years of policy by prohibiting part A providers from representing beneficiaries in appeals. The ostensible reason was that there might be a conflict of interest between the beneficiary and the provider.

A careful review of provider and beneficiary relations does not reveal where such a conflict might arise. Even if a conflict exists in limited circumstances or with regard to an individual case, it is simply wrong for the administration to deny all beneficiaries free choice in selecting a representative.

Rep. Wyden's bill makes it clear that the beneficiary may have as a representative any entity or individual he or she chooses, without restricting that choice solely because the representative is a provider of services.

These matters, while significant and requiring prompt attention, are merely two of a number of due process and fairness problems present in the Medicare program. These issues are the simplest and most straightforward of the problems faced by individuals and organizations participating in Medicare. The problems of arbitrariness and capriciousness, of administrative expediency and programmatic irrationality serve to undermine everyone's support of this most important health care system.

A Medicare program that is fair, that allows for meaningful administrative appeals and the right to judicial review, that is predictable, rational, and objective without meaningless bureaucratic hurdles is, ultimately, in everyone's best interest. Enactment of these two provisions is a step is achieving that goal. Thank you for your consideration.

Mr. WAXMAN. Let me start with Ms. Jones if I might. You suggest that we exempt office visits and the like from any extension of the freeze on physician fees. I take it that would be for both participating and nonparticipating physicians. Are you concerned that this would undermine the participating physician program?

Ms. JONES. No; I think it would give them incentive to do more in the area of home visits and nursing home visits and that kind of thing, which has been somewhat neglected.

Mr. WAXMAN. I like your idea about a commission to review physician fees and make recommendations, and you say it should be modeled after PROPAC. Do you think it should be added to PROPAC or should it be a separate and independent commission?

Ms. JONES. We think it should be a separate and independent commission. We think PROPAC has enough on its back currently, and we think that the membership of the national commission might be better focused on the kind of issues that would be involved.

Mr. WAXMAN. You indicated your strong objection to the Ways and Means proposal for an income-related premium. My colleagues over there say that it is an equitable proposal because it does not increase the total amount of beneficiaries' contributions to part B, but just shifts some of those contributions from low-income elderly to higher income elderly. What is your response to that argument?

Ms. JONES. You are discriminating against the high-income elderly by adding to their income tax when you are not adding it to other people's.

Mr. WAXMAN. Other people?

Ms. JONES. Other than elderly.

Mr. WAXMAN. Other than what?

Ms. JONES. Other than elderly, other than old people.

Mr. WAXMAN. We are asking a certain group of elderly to pay for more.

Ms. JONES. Yes. And you are not treating this like an insurance premium, you are treating it like a benefit. That is for somebody who is in need, and the more well-to-do who pay an insurance premium and then get an income tax because they are getting that insurance. No private insurance would be able to effect that, saying that, "If you bought my policy, then you would have to add to your income tax."

Mr. WAXMAN. Mr. Spielman, I do want to thank you for coming on very short notice to testify today. We appreciate it.

I understand that many of your plans are adopting and expanding their second opinion programs even though they may have doubts about what cost savings they achieve. Can you tell us what the motivation is for putting these programs in place?

Mr. SPIELMAN. There are a number of motivations. I think the most obvious one is a tremendous market demand out there. I think our plans are increasingly incorporating second opinion programs in a comprehensive package of what we call "managed care," which would include preadmission review, second opinions, and discharge planning and that is where the plans are looking in the future, not as a stand-alone program, but part of a broader package.

Mr. WAXMAN. Thank you very much.

Mr. Whittaker.

Mr. WHITTAKER. To really any member of the panel who cares to address it, how many claimants do you expect to take advantage of the hearing allowed under H.R. 2864?

Mr. FRIED. The administrative law judge hearing, Mr. Whittaker?

Mr. WHITTAKER. Yes.

Mr. FRIED. There were 20,000 part B hearings in 1983, when that figure was accurate. Of those, half, about 10,000, would still be under the existing part B hearing officer scheme. The other half would have claims in excess of \$500 and would come under the administrative law judge scheme.

Mr. WHITTAKER. What is the benefit of allowing beneficiaries to be represented by providers such as hospitals or physicians?

Mr. FRIED. It is no secret to anybody in this room that Medicare is one of the most complicated, mind-boggling processes that man has devised on earth. And there simply is seldom going to be an entity better versed in the Medicare Program, more familiar with the claimants' physical problems and the reasons why they needed medical care, than the provider of services that assisted them. It seems to us that it is that entity that is likely to be the most effective advocate for the individual.

Mr. WYDEN. Hats off to the association for standing up for the low income seniors. I think that is really important. It has got to be done these days, and we really appreciate your doing that and also your help on the appeals effort.

Ms. JONES. Thank you.

Mr. WYDEN. Mr. Spielman, I appreciate the opportunity to work with you. I think we are making a lot of progress now. We had a meeting just yesterday with the people from NAIC, and I think the desire of everybody is to make sure that we nurture this infant market and do it in a fashion so as to have some voluntary guidelines—nothing that is mandatory and nothing that could squelch the development of long-term care insurance.

It is my feeling that, if in the next 10 or 15 years we can even get 20 percent of older people to be in a position to purchase long-term care insurance, that is 20 percent of the very great need being handled in the private sector. Thereby it gives us more resources for those who are truly in need.

I want you to know I am interested in the Federal Government facilitating an approach in the private sector and not a role that mandates anything. Senator Durenberger has introduced a companion bill, and that is our very clear desire. We are looking forward to working with you.

With respect to you, Mr. Fried, I think one of the key issues with respect to appeals is the argument the administration has made that somehow when providers and consumers work together, consumers could get ripped off or the Government could get ripped off. One of the things that struck me about the way that you all put together this very broad-based coalition is that if there was any kind of conflict, we would not have had consumers and providers come into my office together and say let's look at a way to deal with the situation.

My question is do all of you at AARP or do you, Mr. Fried, know of any documented instances where there have been conflicts or this kind of alliance used to take advantage of the Government or the consumer?

Ms. JONES. I would say for AARP we do not; but may I add that I did work in Michigan with Blue Cross in relation to appeals, and they gave me statistics at that time, and this was a year or two ago, that they had the informal appeal of 1 or 2 percent where you are sent back the form, the EBO, and said please review this.

I asked them, out of the 1 or 2 percent, which seemed to me very low, how they were decided, and they said 68 percent were decided in favor of the beneficiary, which disturbed me deeply. I thought then that if people knew more about sending them back and what had happened, that they would realize that there were often errors that were not in their favor.

So, even though that sounds like there is not much need because there are so few sent back, I think the percent which are decided in favor of the beneficiaries make it very clear that there is a big need.

Mr. FRIED. Prior to about 15 minutes ago, the answer would have been no. I understand that Dr. Davis came up with apparently the incident that triggered a massive preclusion of representation. Apparently there is a home health agency in Columbus, GA, that may have in a couple of instances improperly represented an individual.

My suggestion to Dr. Davis is that the regulations already provide for a whole scheme that could have been addressed at that particular home health agency that would have precluded them from representing people. It is curious to me that instead of doing that, the agency essentially decided to preclude every home health agency, every skilled nursing facility, every hospital from ever representing a beneficiary.

If ever there was an example of administrative overkill, this seems to be it.

Mr. WYDEN. I am resigned to the fact that the batting average has gone from 1,000 to 0.9999. But it seems to me that that is not very likely to occur, if only because of the role of your organization in senior groups. It would seem to me that you would be very vigilant in looking at these kinds of things.

Aren't there a number of protections built into the system right now in terms of abuses?

Mr. FRIED. As I said, the regulation that describes the relationship between the representative and the beneficiary only provides a whole set of protections that the beneficiary has and that the Secretary or the Administrator can exercise where there is some appearance of conflict.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you.

I want to thank the three of you for your testimony—I'm sorry, Mr. Nielson.

Mr. NIELSON. Two questions.

Mr. Spielman, I thought I heard you say that if they do not have a second opinion, they should not be reimbursed. Did you say that?

Mr. SPIELMAN. I said that in our private business typically plans impose a copayment if the second opinion is not obtained. There is

always reimbursement if the patient goes ahead and has a surgery without adhering to the second physician's point of view. Accordingly payment for surgery is assured.

Mr. NIELSON. Mr. Fried, you were praising Representative Wyden's bill. Do you think \$500 is a good cutoff point? If it is more than \$500, you should go before the ALJ, and less than \$500, it should be taken under part B?

Mr. FRIED. It is a line that we struggle with, and I think that wherever we draw the line, it is going to be difficult. The \$500 is the halfway point.

Mr. NIELSON. Are the ALJ's sufficiently well staffed and sufficient in number that they can take care of the flood of new hearings they would have?

Mr. FRIED. Under this proposal what would happen is the funds that are currently allocated—

Mr. NIELSON. That is not my question. I said are the ALJ's capable of taking care of the flood of new people that they would have to take care of?

Mr. FRIED. Today, the answer is no. By the time this bill became effective, I believe the answer would be yes.

Mr. NIELSON. You sort of implied that HHS does not have much expertise in developing standards for long-term care.

Mr. FRIED. I didn't testify to that issue, sir.

Mr. NIELSON. You said on the basis of one such case, they have made a whole series of new decisions. Let me ask Mr. Spielman that question. Do you think the Department of HHS has sufficient expertise to develop models for long, long-term care insurance?

Mr. SPIELMAN. I do not think it is a question of expertise. It is a question of experience in the marketplace. There simply are not a lot of products out there right now on which to generate a lot of hard analytical information. I think the NAIC is looking at this question. Some further information might be obtained, but I think the question is more related to the market and less to the capability of HHS.

Mr. NIELSON. They don't have the expertise because it is not available in the marketplace; is that right?

Mr. SPIELMAN. Not to a great extent.

Mr. NIELSON. How do you suppose the—how would they do this, then, accomplish this if they do not have enough cases to base it on? How would you do it? How would you develop long-term care insurance?

Mr. SPIELMAN. It is an extremely difficult area and one that we would like to sit down with Representative Wyden and any member of the subcommittee to explore some of the details. I am in no position to suggest a way to implement legislation such as that.

Mr. NIELSON. I would like Mr. Fried to respond to the comment made by Mrs. Jones that she did not believe in taxing those who are older citizens more if they are wealthy than if they are not wealthy. She said that is not fair because you are taxing only the senior citizens; you are not taxing the general public who are wealthy.

Does that square with your suggestion that we should take care of the indigent and those who are retired and don't have the funds to pay for this? How does that square with your thinking?

Mr. FRIED. My comment would be a personal one. My organization does not have a position on this issue. I must say that I have some concern about creating a means test for Medicare in any name.

Mr. NIELSON. You agree with her, basically.

Mr. FRIED. I would be concerned about the proposal that has been discussed, yes.

Mr. NIELSON. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Nielson. Forgive me for almost skipping you.

Thank you very much, the three of you, for your testimony. I think you have done an excellent job, and we appreciate your assistance.

I would like to now call forward for our next panel Paul Willging, deputy executive vice president, American Health Care Association; Josephine M. Driscoll, commissioner, Department of Insurance, State of Oregon; Ron Pollack, executive director, Villers Foundation.

We are pleased to welcome you to the subcommittee hearing, and again, your statements will be made part of the record in their entirety, and we would like to ask you to use no more than five minutes to summarize it.

Mr. Willging, we will start with you.

STATEMENTS OF PAUL WILLGING, PH.D., DEPUTY EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION; MARY HALL, ON BEHALF OF NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; AND RONALD F. POLLACK, EXECUTIVE DIRECTOR, VILLERS FOUNDATION

Mr. WILLGING. I represent the American Health Care Association, the trade association representing the majority of American nursing homes. I am here to express our support for the Long-Term Care Insurance Promotion and Protection Act, H.R. 2293, the Home Respiratory Care Act, H.R. 2703, and the Fair Medicare Appeals Act, H.R. 2864.

With respect to long-term care, Mr. Chairman, this country sees a demographic trend which is on a collision course with constraints on public funding. Right now in terms of the formal support mechanisms for long-term care, which are about \$40 billion per year, public funding accounts for over 50 percent of that resource.

By the year 1990, only 5 years hence, that \$40 billion could well become \$80 billion. There are very few in this country, in Washington, in the States who would argue that Medicaid/Medicare can continue to provide for 50 percent of the price tag of an \$80 billion need.

We clearly need alternative funding sources for long-term care. We would suggest that long-term care insurance is one of those.

There are probably three hurdles that have to be overcome, Mr. Chairman, in terms of the widespread use of long-term care insurance. They relate to product development, they relate to affordability, they relate to marketing.

I think the policies on the market today suggest that we have already dealt with the issues of product development. The policies

can be developed, they can be structured. We have dealt with the issue of affordability. Those policies are reasonable ones. If purchased even as late as age 60 or 65, they can be purchased for \$30 to \$40 per month.

The key issue still facing us in this country is marketing. With respect to that issue, I would contend that we have three subsidiary issues to deal with: consumer information and education, consumer confidence, and credible coverage. We would suggest, and thus the reasons for our support, that the Long-Term Care Insurance Promotion and Protection Act, H.R. 2293, will make a dramatic impact in dealing with those three critical concerns. It will establish a process which in turn will lend itself to model standards which can be accepted by the States, and where those States do not accept them, could be used for a voluntary certification program at the Federal level.

We will deal with the issues of information, confidence and with the critical issue of credible coverage. The time is right. As George Santayana suggested, "He who forgets his history is doomed to repeat it." Let us not go through in long-term care insurance what we went through with Medicaap insurance some 5 years ago. The time is now.

In terms of the Home Respiratory Care Act, H.R. 2703, we do agree that it is time to change the Medicare program so that the ventilator-dependent patient need not receive services only in the \$800 to \$1,400-a-day hospital room, perhaps in the home setting or in the nursing home. We do support that bill.

Enough has been said about the Appeals Act. I would say only instead of referring to conflict of interest, we can have a communion of interest.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Willging follows:]



American Health Care Association 1200 15th Street, NW, Washington, D.C. 20005 (202) 833-2050

STATEMENT OF THE
AMERICAN HEALTH CARE ASSOCIATION
ON
VARIOUS MEDICARE BILLS AND
BUDGET RECONCILIATION CONSIDERATIONS
TO THE
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
U.S. HOUSE OF REPRESENTATIVES
JULY 17, 1985

Mr. Chairman and Members of the Subcommittee:

I am Paul Willging, Deputy Executive Vice President of the American Health Care Association. AHCA is the largest organization of long term care providers, representing about 9000 nursing home-based providers.

I appreciate the opportunity to present our views and recommendations on Medicare issues before the Committee. My statement will focus on AHCA's strong support for three bills: the Long Term Care Insurance Promotion and Protection Act (H.R. 2293), the Home Respiratory Care Act (H.R. 2703), and the Fair Medicare Appeals Act (H.R. 2864).

A non-profit organization of proprietary and non-proprietary long term health care facilities dedicated to improving health care of the convalescent and chronically ill of all ages. An equal opportunity employer.

Private insurance offers a promising approach to purchasing quality long term health care. A large share of Medicaid spending --up to one-quarter of projected outlays--could be saved if more older Americans were insured against the risks of nursing home and other long term care expenses, according to a study commissioned by the Department of Health and Human Services. A significant obstacle to the growth of private long term care insurance is the lack of consumer awareness of their financial vulnerability. Most older Americans assume that public programs, notably Medicare, provide sufficient coverage. Others are misled into believing their "Medigap" insurance provides long term care coverage.

During the past year, two major barriers have been overcome in developing private long term care insurance with the development of actuarially sound policies and the establishment of affordable premiums. More than 25 companies offer policies which cover the costs of long term care, and several other insurers are entering the market. While policies vary greatly, they typically provide an indemnity benefit of between \$30-60 per day for coverage of skilled and intermediate care services for up to four years. It is possible for an individual between the ages of 60-65 to purchase viable long term care insurance at a premium of less than \$30 per month. While coverage for an individual above the age of 75 will be more expensive, data on the income and resources of older Americans suggest that long term care insurance

is within the means of most senior citizens. The challenge is to stimulate effective marketing of new products.

AHCA has provided enthusiastic support for legislation which would initiate a process for developing necessary safeguards for consumers. There are three keys to success in marketing, 1) consumer education, 2) consumer confidence and 3) credible coverage. The process of consumer protection established under the Long Term Care Insurance Promotion and Protection Act (H.R. 2293) helps in all three areas. We commend Rep. Ron Wyden and his numerous co-sponsors, including Reps. Bates, Leland, Luken, Mikulski, Sikorski, and Walgren of this Committee, for their leadership in promoting the concerns of the consumer in this emerging market.

Entering uncharted waters dictates caution. Our goal is to induce a positive federal role in governing marketplace forces without 1) raising jurisdictional concerns, 2) deterring entry into the market of new products, and 3) suppressing state insurance initiatives. Such action, to be effective, must be passable to prevent a slowdown in the momentum towards expanding the market.

In short, H.R. 2293 directs the Secretary to develop model standards for long term care insurance and to extend the process successfully developed for voluntary certification of policies supplemental to Medicare, so called Medigap insurance.

First, the HHS Secretary would develop model LTC insurance standards, in consultation with insurers, senior citizen groups, state insurance commissioners and long term care providers. The standards would include such consumer protections as defining minimum benefits and "pay-out" ratios. Then, for marketing in states which do not enact these or higher standards, a voluntary federal certification would be available to insurers for policies which met the standards. The Medigap provisions for criminal penalties for insurance agents who attempt to use fraud, forgery, or misrepresentations to sell policies would also apply.

The "Medigap" provision provides a useful statutory base. However, it was enacted by Congress in 1980 to deal with a different set of issues, and, therefore, the simple extension of its provisions to long term care insurance would do more harm than good. Decoupling standards for private long term care insurance from standards for Medicare supplemental insurance is a necessary step in informing and educating the buying public. These are two different products being developed by the private sector for insuring against differing risks.

Our national experience with the Medicare supplemental issue proved instructive that attention needs to be given to consumer protection. Initiatives are underway in several centers to develop regulatory guidelines for new long term care products. The insurance commissioners in Massachusetts, Florida, Minnesota and New York have initiated study efforts. Stanford Research

Institute and the Brookings Institution have identified model guidelines as potential products of their study initiatives. The National Association of Insurance Commissioners are pursuing a study approach for developing guidelines. These activities, while most important, are somewhat ineffective without a bridge to public law.

H.R. 2293 initiates a process which takes us through the development and into the implementation of meaningful consumer protection standards. AHCA is calling for more than a study, inasmuch as a study can begin and end without any action. We are calling for a process which will sequentially move us to goal of acceptable policy standards. Federal expectations of consumer protection would be strongly conveyed in the passage of such legislation. It would be a catalyst for the National Association of Insurance Commissioners to speed up work on their model standards for long term care insurance. The several states which are already working on regulatory issues could be assisted by Federal developments.

Positive results which would occur with passage of H.R. 2293 include the following:

- o Federal attention to the developing market,
- o Support for guidelines protecting consumers,
- o Focal point for aggregating support for the market,
- o Positive media activity,

- o Potential for decoupling of long term care insurance from the Medicare supplemental insurance issues,
- o Ability to aggregate input from state and academic study initiatives without preempting their merits, and
- o Potential for raising issues of Federal-state insurance relations without forcing the larger, very controversial issues of the McCarran-Ferguson Act.

The second bill AHCA supports is the Home Respiratory Care Act (H.R. 2703), introduced by Mr. Wyden, with Mr. Florio as one of its co-sponsors. This bill cuts Medicare-Medicaid spending, while improving patient access to needed care, by creating nursing home and home care opportunities for ventilator-dependent persons who would otherwise continue costly hospital stays. Medicare and Medicaid should take financial advantage from the increasingly improving technology for ventilator care outside of hospitals.

This bill is important for removing several Medicare barriers to progressing patients from hospitals to skilled nursing facilities, as soon as medically appropriate. We have a small number of member facilities that currently provide this specialized service under Medicaid, but cannot get Medicare coverage. It should be of special concern to this Committee that Medicaid often gets stuck with the bill for this care because of the Medicare barriers.

The third bill, the Fair Medicare Appeals Act (H.R. 2864), also introduced by Rep. Wyden, includes an important clarification that to secure their rightful Medicare coverage through the claims appeals process Medicare beneficiaries may be represented by the service provider. Many Medicare beneficiaries, because of such situations as their own impairments or lack of family support, are unequipped to battle the cumbersome, intimidating bureaucratic process.

We urge the Committee to approve bills H.R. 2293, 2703, and 2864 and to work for their House passage as soon as possible.

Mr. WAXMAN. Thank you.

Ms. Driscoll.

STATEMENT OF MARY HALL

Ms. HALL. Mr. Chairman and members of the committee, my name is Mary Hall. I am deputy director of the division of insurance from Missouri.

Mr. WAXMAN. Did you know that your name was changed by the tag there?

Ms. HALL. I would like to present a statement that was prepared for Josephine Driscoll, insurance commissioner of the State of Oregon and chair of the Executive Committee of the National Association of Insurance Commissioners. She was prepared to testify before you this afternoon but had to leave because of some other commitments.

I speak today on behalf of the NAIC, an organization of State insurance regulators in the 50 States and the U.S. territories. On behalf of the NAIC, I applaud Congressman Wyden and this committee for your interest in long-term care issues.

The NAIC identified long-term care needs of senior Americans as a priority some months ago and has established a task force of insurance regulators chaired by David Childers to address these issues. An advisory committee comprised of representatives of AARP, health insurers who are present or potential writers of long-term care products, trade associations and other health care professionals was appointed by David Childers and has already begun its work in this area.

An invitation was extended to Congressman Wyden yesterday to participate in the NAIC efforts, and I am offering today to share with this committee on an ongoing basis the work product of the NAIC and its advisory committee.

Let me give you an example of the efforts that are currently under way. A consumer booklet is being designed which will answer in easy-to-read language the most commonly asked questions about long-term care products. The brochure will define the key terms of intermediate and custodial care. It will define the long-term care benefits available in each State and the cost for these benefits.

The booklet will be distributed free of charge in the State by the NAIC and the insurance commissioners. In addition, the NAIC is developing public service announcements which will focus on frequently asked questions about Medicare coverage and long-term care.

These announcements will give the listener information about how to contact their State insurance departments for more detailed information.

All of these efforts are designed to educate the public in increased consumer awareness of long-term care issues. Additionally, the advisory Committee will explore how conventional insurance coverage can be adapted for reimbursement of long-term care expenses, as well as considering alternative funding mechanisms.

For each coverage, the committee will provide a description of the product, illustrate how it will benefit long-term care, list bar-

riers to using the coverage for long-term care expenses, determine acceptability to consumers, regulators and the insurance industry, and identify what changes in insurance regulation in the Federal tax laws would be necessary.

Another focus of the advisory committee is examination of tax incentives and other legislative action that would encourage the availability of long-term care products.

Another subgroup is collecting actuarial data. Additional time and effort will be devoted to analyzing the need for model legislation. I believe the foregoing indicates the commitment of the NAIC to identify and find solutions for long-term care needs facing us today.

We ask that the extensive work under way to explore private and public financing alternatives be considered and the proposed legislation be amended to place responsibility with the NAIC and the various States.

Thank you.

Mr. WAXMAN. Thank you very much.

Mr. Pollack.

STATEMENT OF RONALD F. POLLACK

Mr. POLLACK. Thank you, Mr. Chairman.

Thank you for your invitation to participate in this hearing specifically to talk about H.R. 2293, Long-term Care Insurance Promotion and Protection Act.

I want to commend Representative Wyden for his thoughtfulness in introducing the bill and again thank the subcommittee for its leadership in the creation of the home and community-based care waivers.

One word about our organization, and then briefly our testimony. The Villers Foundation was created in 1982 for the purpose of improving the lives of low and moderate income elders. We conducted meetings around the country at the beginning of the foundation, and one of the things that we found in the meetings was that perhaps the most important concern elders had was health care, and particularly chronic care.

We have joined together with several other foundations, the Robert Wood Johnson Foundation, Hartford Foundation, Retirement Research and Greenwall Foundation, in looking at financing options for comprehensive long-term care services. There is a study being conducted by Alice Rivlin and Joshua Weiner at the Brookings Institute. We look forward to the results of that study.

I wanted to make three essential points with respect to the legislation that Congressman Wyden introduced. First, private insurance is becoming sufficiently widely discussed—

Mr. WAXMAN. Let me interrupt you. We have a vote on the House Floor and Congressman Wyden is going to be back here before I return because he was going to catch the vote and come back, and I'm sure he will want to hear your comments, so if you would not mind just stopping right there, let's wait until he gets back and then we will reconvene.

We will recess now for however long it will take before Congressman Wyden returns.

[Brief recess.]

Mr. WYDEN [presiding]. Chairman Waxman has said in the interest of time and making sure you all are not having your breakfast here tomorrow morning, let's move right along.

Mr. Pollack, please.

Mr. POLLACK. We were singing, "Will he ever return? No; he'll never return."

I was going to comment on the bill you introduced, H.R. 2293, and had commended you for the thoughtfulness in introducing the bill, and I will do it again in your presence.

Mr. WYDEN. The Chairman said I should come back for the music.

Mr. POLLACK. Now you know why.

There are three key points that I wanted to raise with respect to the bill that you introduced. First, private insurance is becoming sufficiently widely discussed that I think it is time to consider basic consumer protections. We recognize that only 1 percent of nursing home costs right now are covered by private insurance; however, some policies are currently being marketed.

We just heard that AARP is in the process of developing a limited offering with respect to private insurance. Insurance is certainly going to be a significant temptation for those who want protection from nursing home costs, and for those people who are facing \$1,500 or \$3,000 bills per month of nursing home costs, certainly private insurance is going to be a very significant temptation.

I think the bill that you have introduced is a modest but important effort at providing some protection modeled to similar legislation in the Medigap area, and based on our experience with respect to Medigap, we have reason to believe that some kind of protection is going to be necessary.

The Medigap experience may well be instructive. We know that individuals were duped into buying duplicative policies. We know that administrative and monitoring costs plus profits were extraordinarily high under numerous policies. We know that benefits were limited in some cases to dread diseases. We know that one congressional estimate says that as many as 23 percent of the policies purchased involved duplicative coverage.

I think in the area of long-term care, having some modest protection makes a great deal of sense. People are not thoroughly familiar with what their options are under long-term care. AARP conducted a survey of its membership a while ago, and they found that 80 percent of their membership believed that Medicare covered long-term care services.

Clearly, there is a great deal of confusion in the area of tremendous concern for people, there is need for some kind of protection, and the modest steps that you have called for, we think, are commendable.

The second point. I think it is important to note that your bill provides appropriate protections so that all interested parties are going to be participating in determining what standards must be met to gain a seal of approval. I think it is very important that we involve the consumer as well as the insurance industry, and I think you are to be commended particularly for that provision.

Finally, the last point that I want to make with respect to your legislation is I want to place one caution with respect to reliance on private insurance to solve our long-term care needs now and in the future. Several points I would want to make about that.

First, the insurance that is being contemplated is generally going to be a fairly high cost. It means that the costs of these policies are going to be out of reach for a substantial number of people. A recent study by IFC Inc. funded by HCFA apparently assumes under its most generous assumptions that only 21 percent of the elderly will be able to afford private insurance, so it gives you a sense of the limitation even under generous assumptions.

And second, private insurance tends to have a limited scope of coverage. It tends to focus on institutional care because it needs to focus on an insurable event, and we are concerned about steering people toward institutional care when perhaps more appropriate care should be made available to them, and so private insurance really only provides a limited benefit, and we should be well aware of that.

We should also recognize that private insurance will only achieve minimal savings in the public sector, particularly with respect to Medicaid costs. ICF's assumptions are that private insurance is not going to save a significant percentage of Medicaid costs, largely because of the different target populations, and so I think we need to well understand that private insurance, if it is to be a significant factor in our equation of long-term care, it is only a limited factor.

One final observation. Not very far below the surface, those of us who are concerned about low and moderate income elders harbor one even greater reservation about the movement toward a private long-term care insurance system. We are concerned about the impact of a fast-developing private market and a long-term care insurance on the needs of low and moderate income elders, the ones most at risk of being institutionalized.

Poor aged are six times more likely to reside in nursing homes than the nonpoor aged. We know that today's long-term care system involves a mixture of private and public funds. We know that tomorrow's system, a real system, it is hoped, will require much greater amounts of money, perhaps as much as three or four times as is being spent today. What is the appropriate shape of such a system? How should services be organized and delivered? What is the proper public/private mix for financing and control?

I submit we do not know the answers to all of these questions, and yet we know from the experience in acute care that the presence of private insurance, even the perception that private insurance is widely available, can erode society's willingness to committing public resources to meeting the needs of those unable to use the private system.

In terms of the subject before us today, that translates into these words of caution: Don't let us slip into the easy response, "Let the private sector do it." A very thorny problem, one that will absolutely require greater public commitment, is actually what we are facing. Nonetheless, private insurance is a reality that elders in need of long-term care protection will have to cope with.

So we commend the initiative of Congressman Wyden in introducing H.R. 2293, which sets out minimal steps to ensure that long-term care insurance develops in the least harmful way possible.

Thank you.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Mr. Pollack follows:]

LONG-TERM CARE INSURANCE:
FIRST STEPS SHOULD INCLUDE STRONG CONSUMER PROTECTION

STATEMENT BY RONALD F. POLLACK, EXECUTIVE DIRECTOR
VILLERS FOUNDATION
BEFORE THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, D.C.
Wednesday, July 17, 1985

Mr. Chairman and members of the Subcommittee, I am pleased to be invited to testify today on the subject of long-term care insurance. You have before you H.R. 2293, the proposed Long Term Care Insurance Promotion and Protection Act, and I would like to express strong support for the thrust of this important legislation introduced by Congressman Ron Wyden.

The Villers Foundation, established in 1982, has as its top issue priority improvement in the lives of low- and moderate-income older people. Meeting the health care needs -- both acute and chronic -- of that group of people is a subject that elders themselves believe should be at the top of any policy agenda.

Long-term care services include a range of social and health care services for persons who are so functionally disabled that they require assistance with activities of daily living. Medicare, which protects nearly all older people, provides few of these

services, and limited amounts of those it does provide. Medicaid, which is available to those with extremely limited financial means, covers institutional long-term care services. This sub-committee deserves great commendation for the leadership it has shown in enacting -- and protecting -- the mechanism for allowing greater home- and community-based services to be available under Medicaid.

For one reason or another, though, most Americans in need of long-term care services today don't have a reliable source for them. Even more compelling is the growth over the next period of years in the numbers of those needing long-term care. Those likeliest to need the care -- those over the age of 85 -- will double in number by the year 2000, to more than five million. And that's before the demographic tidal wave of Baby Boomers washes over the country's long-term care system.

How will long-term care to all who need it be financed, both now and in the future? Villers has joined a number of other funders in supporting a study being conducted by Alice Rivlin and Joshua Wiener at the Brookings Institution of a number of possibilities. One of those options, which has been written about for some time in very hopeful terms, is long-term care insurance offered by private insurers.

So far, those few companies offering long-term care insurance have not attracted many takers -- only 1% of nursing home costs are paid from private insurance. A variety of factors could explain this -- most notably, uncertainty by insurance companies over the risks involved. (Perhaps the toughest hurdle for insurance companies to overcome is the overwhelming belief among the elderly that they already have long-term care insurance under Medicare.)

Nonetheless, some policies are being marketed, and, as the subcommittee has heard, AARP is about to offer a major new policy to its membership. The fact is, almost half of the cost of institutional long-term care comes out of the pockets of the elderly and their families. They have no other protection. Currently, a nursing home bed could cost anywhere from \$1,500 to \$3,000 a month. And the very fact that private insurance is becoming so widely discussed makes it important that measures like H.R. 2293 be given serious consideration.

This bill is patterned after the existing voluntary certification plan for Medicare supplement private insurance, or "Medi-gap." Its aim is to prevent some of the abuses that caused Congress to enact the Medigap voluntary certification program in the first place. There was abuse in the marketing of these policies, particularly in those sold individually. Agents often duped unsuspecting older people into buying duplicative, or worthless, policies -- as many as 20 or 30 to the same person. Administrative

and marketing costs, along with profit, often consumed as much as 50-70% of the premium revenue (by contrast, Medicare itself spends 94-95 cents from each program dollar on benefits). Benefits were often limited to specific "dread diseases," though the risks were much broader. One Congressional estimate was that as many as 23% of those purchasing Medicare supplements had some degree of unnecessary coverage.

Congress confronted, of course, the tradition that regulation of insurance is a matter only for the states, which led to the voluntary certification program now in place. The federal statute set minimum standards which, if met, allowed insurance companies to use a "seal of approval" in their marketing. States could set higher standards if they chose -- and indeed, since the program's enactment in 1980, every state has put in place voluntary standards for Medigap policies that meet or exceed the federal standards.

H.R. 2293 adopts for long-term care the same device for a voluntary certification program, with minimum federal standards and the option for states to put tougher ones in place. Long term care is even more complex, less familiar to the average potential insurance buyer, and the fears surrounding the need for it just as great or greater as with acute care.

There has been some criticism of the approach in H.R. 2293

as being premature, since so many questions need to be sorted out about what constitutes a reasonable long-term care insurance package. But that hasn't stopped the marketing of these policies, and the momentum is building. If consumers are going to have to make tough choices about long-term care insurance policies, Congress should be prepared to help them get as much useful information as possible about those choices.

One particularly appropriate provision of H.R. 2293 is its convening of all interested parties, including consumer representatives, to arrive at the proper standards that private insurers would have to meet to get the seal of approval. We would urge that that requirement be retained, and perhaps even strengthened. The standards need to be thought out very carefully. If the proliferation of private policies is somewhat slowed, that might not be such a bad thing; for many of us concerned about moderate- and low-income elderly, several facts about this topic give pause:

High cost. Only relatively well-off elderly (or near-elderly) will be able to afford these policies. A study last year commissioned by HCFA concluded, using generous assumptions about willingness and ability to pay, that only 21% of the elderly could afford the most common nursing home care policy.

Limited scope. Many existing policies cover only nursing home care. If we are to avoid massive construction of new nursing home beds, and provide maximum opportunity for independence,

non-institutional benefits should be included. This will also help develop service capacity where little or none exists today.

Displacement of the poor. If constraints continue on new construction, and Medicaid reimbursement rates continue to lag behind private pay rates (including those paid by those with private insurance), nursing home operators will have strong incentives to replace those on Medicaid, or those requiring heavier care, with private patients whose care needs are lighter and source of payment more lucrative.

Minimal savings. Though some pressure on public programs could conceivably be lessened through the development of private long-term care insurance, the same HCFA-sponsored study estimated the savings to Medicaid from such insurance at just 8% of projected expenditures -- not insignificant, but not enough to deal with the gross shortcomings in that program.

Final Observation

Not very far below the surface, those of us concerned about low- and moderate-income elders harbor one even greater reservation about the movement toward a private long-term care insurance system. We are concerned about the impact of a fast-developing private market in long-term care insurance on the needs of low- and moderate-income elders, the ones most "at risk" of being institutionalized. Poor aged are six times more likely to reside in a nursing home than the non-poor aged.

We know that today's long-term care "system" involves

a mix of private and public funds. We know that tomorrow's system -- a real system, it is hoped -- will require much greater amounts of money, perhaps as much as three or four times what is being spent today. What is the appropriate shape of that system? How should services be organized and delivered? What is the proper public-private mix for financing and control? I submit that we don't know the answers to all of those questions yet. And yet we know, from the experience in acute care, that the presence of private insurance -- even the perception that private insurance is widely available -- can erode society's willingness to committing public resources to meeting the needs of those unable to use the private system.

In terms of the subject before us today, that translates into these words of caution: don't let us slip into the easy response -- let the private sector do it -- for a very thorny problem, one that will absolutely require greater public commitment.

Nonetheless, private insurance is a reality that elders in need of long-term care protection will have to cope with. So we commend the initiative of Congressman Wyden in introducing H.R. 2293, which sets out minimal steps to assure that long-term care insurance develops in the least harmful way possible.

Thank you very much for this opportunity to share our views on this timely and vital subject.

Mr. WAXMAN. I express my appreciation to the three of you for your testimony.

Mr. Wyden, you have some questions.

Mr. WYDEN. Thank you very much, Mr. Chairman.

It is a privilege to work with each of you and your organizations in the last few months as we have tried to go forward with this effort.

I think your last point, Mr. Pollack, going right into this debate, this is no panacea, I think we have all got to understand that.

You have noticed that Chairman Waxman has led the fight for improvements in Medicare, improvements for the aged. I think we have to integrate the various kinds of resources so we can put together what amounts to a continuum of long-term care.

There are a variety of different kinds of alternatives. We don't just stand there and say this will do it or this will do it or this will do it. I think all of you have made very great contributions in terms of this effort.

I think the only substantive question I had is where are you in the process at the NAIC? I know you had several of these big meetings. I very much appreciate the chance to participate with you.

I know you have a committee and a system in place to start looking at these issues. I would just be curious where that is in terms of the NAIC kinds of committee systems.

Ms. HALL. The advisory committee has been appointed, and since I am not personally serving on that committee, I cannot really be responsive to that question, but other members of the NAIC who have offered their assistance to work with you will be happy to discuss it with you.

Mr. WYDEN. I was very pleased at the meeting with your people yesterday. I think we are on the same wave length. Now we get down to the mechanics of coming up with something that really does what we want, and I think this is twofold. One thing we want is to promote so we can get more companies into the field. Mr. Willging, the numbers that I have been hearing are that there are 20 to 25 people in the field on an ongoing basis. A leader in the field are Fireman's Fund and Mass Indemnity. We want to promote more companies to enter the field.

And then the second thing we want is to make sure that we don't wake up here in a few years and find ourselves in the middle of what happened with the Medigap policies ten years ago. I was director of the Gray Panthers at that time out in Oregon. The seniors called it the "Medigyp" policy. It just seemed that there was not any there. I know because of the efforts of you three, we won't have with long-term care the same kind of process that created the Medigap problem. We appreciate all of you.

Mr. WAXMAN. Thank you very much, Mr. Wyden; and thank you for your testimony.

For our next panel, we would like to hear from Dr. Jerald R. Schenken, board of trustees, American Medical Association, and Dr. N. Thomas Connally, chairman, governmental activities, American Society of Internal Medicine.

We are pleased to welcome the two of you to our subcommittee here today. Your prepared statements will be made part of the

record in full, and we would ask you, if you would, to summarize your statement in no more than 5 minutes.

Dr. Schenken, why don't we start with you.

STATEMENTS OF JERALD R. SCHENKEN, M.D., BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; AND N. THOMAS CONNALLY, M.D., CHAIRMAN, GOVERNMENTAL ACTIVITIES, AMERICAN SOCIETY OF INTERNAL MEDICINE

Dr. SCHENKEN. I would like to mention to you that there are some subjects, such as unnecessary surgery, national fee schedules, rural labs, the insurance versus prepayment concept, and some other funding problems of long-term care that I am not prepared to address in the oral statement. We would like, perhaps to communicate later with you on some of those issues.

Mr. WAXMAN. We would like to have your views and we will hold the record open to receive them.

Dr. SCHENKEN. The AMA is pleased to have this opportunity to present our concerns over proposed budget cuts in the Medicare Program. We are concerned that further major cuts in the program will harm those who can least afford it, erode the quality of health, jeopardize access to physicians and other providers of health care, and unfairly shift costs to other segments of society.

The AMA opposes continuation of the freeze on Medicare reimbursement and physician fees. We support an appropriate increase in Medicare physician and hospital reimbursement as now provided by law unless the Congress legislates an across-the-board freeze of domestic and defense spending as part of a broad program to reduce the Federal deficit and bring stability to our economy. Absent such an across-the-board freeze, the AMA does not believe it appropriate for Medicare to bear the brunt of efforts to hold in line governmental spending.

The AMA opposes the reduction in direct graduate medical education funding recently implemented by the Department of HHS. We urge this committee to adopt provisions to reverse the administration's actions: We are also particularly concerned over the proposed 50-percent cut in indirect medical education costs. Many inner city teaching hospitals whose residents provide substantial amounts of care to the poor would be severely affected.

The AMA strongly believes that an indepth study of the financing of graduate medical education should be undertaken before Congress considers further changes. To this end, the AMA has a committee that is undertaking such a study. We will be glad to share the deliberations of that committee with you.

A proposal calling for a mandatory second opinion program for elective surgical services for Medicare beneficiaries has been receiving attention as a potential for program savings. However, the potential for savings from such a program may be illusory. A July 1 report from the CBO called estimated savings very uncertain, and went on to state:

Because no study has been done on the reduction in surgery rates in Medicare among the aged population as a result of mandatory surgical programs, the Second Surgical Opinion Program's (SSOP) effects are largely speculative. It is possible that costs of an SSOP could exceed any savings or that savings could even be higher than our estimates.

The AMA is opposed to a mandated second surgical opinion before every elective surgical procedure. This imposition into the existing patient-physician relationship could have a deleterious effect on the relationship and could impose an element of doubt in the patient's mind at a time when the patient is most in need of a strong belief in the views and abilities of his or her physician.

Patients should be presented with the option of seeking second opinions for treatment decisions instead of being automatically subjected to these mandatory opinions. The AMA is a long-time supporter of second opinions and has recommended that they be done at any time that the patient or physician feels that they are necessary.

We believe that patients will well be served if the Federal Government encourages second opinions rather than mandating them. We have no opposition to the second opinion process itself; it is the mandatory program that is the problem.

With regard to H.R. 2864, Mr. Wyden, we support it and are with you on this issue.

In conclusion, Medicare beneficiaries are entitled to high quality health care services. We are concerned that budget proposals will have an adverse impact on the ability to physicians, hospitals and others to assure Medicare beneficiaries the quality of services they are promised.

Mr. Chairman, I will be glad to respond at this time or later to whatever you would request.

[Testimony resumes on p. 534.]

[The prepared statement of Dr. Schenken follows:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION

to the
Subcommittee on Health and the Environment
Committee on Energy and Commerce
United States House of Representatives
Re: Fiscal Year 1986 Medicare Budget Proposals

Presented by: Jerald R. Schenken, M.D.

July 17, 1985

Mr. Chairman, and Members of the Committee:

My name is Jerald R. Schenken, M.D., and I am a physician in the practice of pathology in Omaha, Nebraska. I am a member of the Board of Trustees of the American Medical Association. Accompanying me is Ross Rubin, Director of the AMA's Department of Federal Legislation.

The American Medical Association is pleased to have this opportunity to appear before this Committee to present our concerns over proposed budget cuts in the Medicare program. While some of the Administration's Medicare budget proposals for Fiscal Year 1986 warrant support, proposed cuts to the Medicare program being considered continue the practice of the last five years of targeting Medicare for an inequitable burden of federal spending reductions. Further major cuts in Medicare will harm those who can least afford it, erode the quality of health care, jeopardize access to physicians and other providers of health care, and unfairly shift costs to other segments of society.

The American Medical Association appreciates the difficult decisions that this Committee is facing. Indeed, you are facing a true dilemma. On one side there is the need to find savings in the federal budget and on the other is the responsibility to assure the availability of high quality health care services for the Medicare population.

The AMA is strongly committed to restraining health care expenditures. In response to an AMA call to all physicians in February 1984, physicians voluntarily agreed to freeze their charges to all patients, not just Medicare beneficiaries, for a one-year period. Compliance with this freeze was substantial, with 63% of all physicians not raising their fees for the entire year that the fee freeze request was in effect. The resulting savings from this voluntary activity was an estimated \$3.1 billion dollars that otherwise would have been spent for physicians' services. The voluntary freeze was a significant factor in the recent slow-down in the rate of increase in the cost of physicians' services.

Even though the one-year voluntary fee freeze period has expired, the AMA continues to urge physicians to consider each patient's financial needs when setting charges and to accept Medicare assignment, reduce fees, or charge no fee at all in financial hardship cases.

NEW REVENUE SOURCES

Additional sources of revenue should be used to avoid further cuts in important health care programs. Specifically, we support an increase in the cigarette tax to 32¢ per package to generate an additional \$6.5 billion. We also support an increase for the tax on alcoholic

beverages. These revenues should go to the Medicare trust funds and greatly diminish the need for continued cuts. This action would both discourage use of alcohol and tobacco and assist in achieving public health goals.

NEED FOR LONG-RANGE ANALYSIS AND SOLUTIONS

With a program as important and complex as Medicare, we believe that modifications should be viewed in the broader context of providing health care for the elderly and disabled today and well into the next century. Even though the date of predicted insolvency for the Medicare Hospital Insurance Trust Fund was set back to 1998, this program needs substantial modifications. Congress now should start addressing the long range viability of the program.

The American Medical Association has taken a lead role in looking for long-range solutions to today's and tomorrow's health problems. In 1982, we initiated the Health Policy Agenda for the American People project to develop a philosophical and structural framework to aid in developing future health policy that will assure the availability of high quality health care services for the American people. The AMA has committed over \$3 million to this project which involves over 150 organizations including representatives of medicine, government, nursing, labor, business, the hospital industry, health care payors and the public.

In addition to this broad-based AMA-sponsored program, the Association is also looking for long-range solutions to the problems of the Medicare program. The AMA has recently issued two major reports on the Medicare program. The first report identified a series of proposals that should be considered to assure solvency of the program for the short

term. The second report (attached to this statement) sets forth a series of options for the Medicare program. The Association is studying proposals to utilize new concepts to change funding for health care for the elderly from the current pay-as-you-go program to a self-funding system where resources will be set aside to provide real trust funds for the future. We believe that such a program can be workable and is essential if to end the annual budget crises in health care programs.

Congress has made a commitment that the health care needs of the elderly will be met. We are concerned that continued annual cuts in Medicare will result in this promise being broken. We are committed to the development of a rational proposal to aid the nation in fulfilling its obligation to the elderly of today and the future.

FISCAL YEAR 1986 BUDGET PROPOSALS

The two major features in current budget proposals for Medicare savings involve a freeze in the reimbursement level for hospital services and a continued freeze on both maximum program reimbursement and actual fees for physicians' services provided for Medicare beneficiaries.

The AMA opposes continuation of the freeze on Medicare reimbursement and physician fees. We support an appropriate increase for Medicare physician and hospital reimbursement as now provided by law, unless the Congress legislates an across-the-board freeze of domestic and defense spending as part of a broad program to reduce the federal deficit and bring stability to the economy. Absent such an across-the-board freeze, the AMA does not believe it appropriate for Medicare to bear the brunt of efforts to hold the line on governmental spending.

PHYSICIAN REIMBURSEMENT UNDER THE MEDICARE PROGRAM

The American Medical Association is opposed to a continuation of the freeze on physician reimbursement and fees under Medicare. In the last Congressional budget cycle, the only freeze imposed was placed on physicians. Continuation of the freeze would extend an unfair and extremely discriminatory practice. Other elements of the economy are not being asked to undergo similar restraints in payment from the federal government. An extension of the freeze would be particularly discriminatory as only physicians would be subjected to a 27-month freeze.

Under the Deficit Reduction Act of last year, the increase in the Medicare prevailing rate scheduled for July 1, 1984 was eliminated, and the July 1, 1985 increase was postponed until October 1, 1985. A further postponement of one year will mean that there would be no allowed increase from July 1, 1983 through September 30, 1986 -- a 39-month freeze. Moreover, because of Medicare's payment structure, reimbursement for most of 1986 will be based on 1982 charges.

The proposal to continue the freeze for an additional year will unduly extend the existing lengthy time lag in reflecting changes in reimbursement. This proposed action will have a number of negative results and prove to be counterproductive. A continued freeze will not only discourage physicians from accepting assignment, it may discourage physicians from treating Medicare beneficiaries. For those physicians who continue to treat Medicare beneficiaries, their ability to acquire new equipment and adopt new technologies and to meet increased costs, including the costs of professional liability insurance, will be reduced.

Selective Increases in Reimbursement are Inappropriate

Failure to allow increases in physician reimbursement and to terminate the fee freeze, will be contrary to the commitment made by Congress. As a part of the Deficit Reduction Act, all physicians were promised an increase in the Medicare reimbursement rate on October 1, 1985.

Some Members of Congress have indicated that only the "participating physicians" should receive an increase in reimbursement under Medicare. We do not believe that such an action is fair or appropriate. Furthermore, these physicians have already been given favorable treatment under the Deficit Reduction Act as their fee profiles will be allowed to reflect increases in their fees made during the current fifteen month freeze. Allowing an increase in reimbursement for only "participating physicians" would perpetuate and aggravate the current discrimination in the law. An equal increase should be provided to all physicians so that the value of Medicare coverage will not be eroded for those beneficiaries who choose to receive their medical care from non-participating physicians.

The AMA also is very concerned over the perception created by statute that there are separate classes of physicians providing care under the Medicare program. While Medicare now recognizes "participating" and "non-participating" physicians, in reality both groups of physicians are encouraged to provide care for Medicare beneficiaries. In some situations there is no difference between physicians in these two categories other than the label. While "participating physicians" are identified as accepting assignment on 100% of all claims, there are

"non-participating physicians" who also accept Medicare claims on an assigned basis 100% of the time. Indeed, 23% of the physicians who had accepted 100% of their claims on an assigned basis prior to the participating physician program did not elect to "participate" under the new law.

When Congress promised an increase in the Medicare prevailing charge level on October 1, 1985, for all physicians, it also indicated that during the freeze only "participating physicians" would be allowed to increase charges and have these increases considered in updating customary charge profiles. As payment of the customary charge level rate cannot exceed the prevailing charge level rate, a failure to grant an increase in the prevailing charge level would result in no increased Medicare reimbursement for many "participating" and "non-participating" physicians who take assignments.

Continuation of the Fee Freeze and Reimbursement Limits is Inequitable

A continuation of the fee freeze and reimbursement limitations will work particularly severe hardships on physicians and their patients in situations where the physicians' fees have been frozen at a relatively low charge level, and where physicians did not increase their fees during the AMA's voluntary fee freeze. These physicians will be penalized for their good faith effort to hold the line on health care expenditures.

Another group of physicians who will be particularly hard hit are provider-based physicians. Provider-based physicians who had been reimbursed through a combined billing process prior to October 1, 1983, did not have a customary charge profile in effect when the fee freeze was instituted. Their interim profiles, pending the determination of actual

customary charges, were set according to "compensation-related customary charges." Because the Deficit Reduction Act prevented any redetermination of customary charge profiles, these physicians were frozen at a charge level that in many instances is dramatically below the customary and prevailing charge in the community.

Acceptance of Assignment

A continuation of the Medicare reimbursement limitations and the fee freeze will discourage physicians from accepting Medicare claims on an assigned basis. This could reverse the current trend of continually increasing rates of assignment. The ability of physicians to accept assignment on a claim-by-claim basis is an important element of Medicare that assures beneficiaries access to virtually any physician. The history of physician acceptance of assignment bears out the fact that physicians do recognize the financial needs of their elderly patients and that they do accept assignment where warranted.

Continuing a trend started in 1976, the rate of assignment of all claims has increased from 50.5% in 1976 to 69.3% in May of this year. Clearly, we are at a point where those Medicare beneficiaries in need of health care services at reduced fees readily should be able to find a physician who will accept Medicare assignment.

Discourage Treatment of Medicare Beneficiaries

The current freeze imposed on physician reimbursement along with the freeze on increases in physician fees has already resulted in some physicians finding it difficult to continue treating Medicare beneficiaries. This has resulted in a break in valuable physician/

patient relationships as these patients have been forced to seek their care from others. A continuation of the reimbursement limitations and the fee freeze can only exacerbate these problems.

For many physicians, accepting Medicare assignment and even treating Medicare beneficiaries in the future will only be done at an economic loss. Those physicians who have tried to hold the line on increasing health care costs, including those who responded to the AMA voluntary fee freeze, will be the first to face the decision of whether to continue to provide care for Medicare beneficiaries. These physicians would be penalized for their act of good faith in voluntarily freezing fees. A continuation of the freeze can only continue to hit hardest those who have tried to hold the line on increasing health care costs.

Mr. Chairman, the American Medical Association urges this Committee to reject proposals to continue the physician reimbursement limitations and fee freeze under Medicare. Continuation of the freeze represents a major step away from accomplishing the goals of the Medicare program to assure access and quality care for the nation's elderly and disabled.

FREEZING PAYMENT RATES TO HOSPITALS

The AMA is also opposed to the proposed freeze in hospital reimbursement for services provided Medicare beneficiaries. The imposition of such a freeze mid-way through the phase-in process of the prospective pricing system (PPS) would be particularly damaging to the quality of health care services. Indeed, such an act would be violative of the very prospectivity of the PPS.

When Congress created the PPS as part of the Social Security Amendments of 1983, the program was advocated as a way to provide

hospitals with incentives to provide appropriate yet economical services. A freeze or further reimbursement cuts would be ill-advised and could compromise the ability of hospitals to meet the needs of the elderly.

A recent report by the General Accounting Office (GAO) raises substantial concerns about the actions of hospitals in discharging patients in a poorer health status than prior to implementation of PPS. We strongly believe that, until concerns raised in the GAO report and in hearings held earlier this year are answered, a freeze on the prospective payment rate will aggravate the current problems.

MEDICARE REIMBURSEMENT FOR GRADUATE MEDICAL EDUCATION

The Administration's fiscal year 1986 budget proposes to reduce Medicare reimbursement for teaching hospitals' direct medical education costs to the levels that prevailed during hospital accounting periods ending in calendar year 1984. The Administration has published a Final Rule to this effect. The President's budget also would cut indirect medical education payments by 50%. In addition, there are numerous proposals before Congress to modify Medicare payments for GME.

The AMA opposes the reductions in graduate medical education funding implemented by the Department of Health and Human Services and urges this Committee to adopt provisions to reverse the Administration's action. We also are particularly concerned over the proposed 50% cut in indirect medical education costs. Many inner-city teaching hospitals whose residents provide substantial amounts of care to the poor would be severely affected. We also believe it is premature to alter hospital reimbursement until sufficient data is available concerning the impact of

the recently implemented PPS. This is particularly true in light of a fundamental flaw in the DRG system — the failure to reflect severity of illness and case-mix differentials.

We believe that modifications may be made for direct GME funding consistent with the following points:

- o opposition to a freeze on direct medical education costs unless such a freeze is part of an across-the-board freeze on all domestic and defense spending;
- o support for limiting the number of residency years (5 years) reimbursed by Medicare if proper assurances are given to provide adequate funding for residents whose training programs extend beyond the limit; and
- o support for limiting Medicare funding to graduates of accredited medical schools (LCME and AOA). Other sources should be utilized to fund residency training for foreign students who are to return to their native country to practice medicine. Provision should be made to ensure an orderly transition for hospitals that rely on FMGs to meet patient care needs.

The AMA believes strongly that an indepth study of the financing of graduate medical education should be undertaken before Congress considers further changes. To this end, an AMA Ad Hoc Committee has begun a thorough study of GME financing.

DELAY IN THE INITIAL DATE OF ELIGIBILITY FOR MEDICARE

Under existing law, a person is ordinarily covered by Medicare on the first day of the month in which he or she reaches the age of 65. The Administration's budget proposes that eligibility for Medicare be deferred to the first day of the month following an individual's 65th birthday.

In recognition of the fact that there is a need to achieve budget savings in the Medicare program, the Association supports this proposal. Such a modification in the date of eligibility for Medicare benefits

should not result in Medicare beneficiaries facing uncovered costs as most existing health insurance policies provide coverage until the date when Medicare coverage begins.

MEDICARE AS SECONDARY PAYOR FOR WORKING BENEFICIARIES OVER AGE 69

The Medicare program currently provides that working beneficiaries and their spouses up to age 69 have the option of keeping employment-based health insurance as primary health care coverage, with the Medicare program providing secondary coverage. The new proposal would extend this option for Medicare beneficiaries over age 69.

The AMA supports this proposal. The ability to maintain health care coverage under an employment-based policy will provide continuity of care. Also, as such an extension is optional for the Medicare beneficiary, individuals will not lose any of their rights under this proposal.

INCREASING THE PART B PREMIUM AND DEDUCTIBLES

The Administration's proposed budget calls for gradual increases in the Part B premium so that it will cover 35% of Part B program costs by 1990. In addition, the proposal calls for increasing the Part B deductible based on the rate of increase in the Medicare economic index.

The AMA supports increasing the Part B premium and deductible to cover 35% of total program costs. Such an action is in keeping with the original intent of the Medicare program. Originally, the program was to be funded one-half by general revenues; however, general revenues now fund approximately three-fourths of the Medicare Part B program.

Medicare, like insurance programs, should have appropriate front-end copayments and deductibles. We recommend, however, that rather than

tying the indexing of the Part B deductible to the Medicare economic index, this deductible should be tied to the medical care component of the Consumer Price Index to reflect more accurately changes in the costs of medical services. Also, increases in the Part B premium and deductible should be structured to reflect financial resources of Medicare beneficiaries.

COPAYMENTS FOR HOME HEALTH VISITS

The Administration's budget proposal calls for copayments for home health visits after the first 20 such visits. These copayments would be equal to one percent of the hospital deductible.

The AMA supports this proposal which would encourage appropriate consumer awareness of health care costs. We believe that reasonable coinsurance amounts will not deter beneficial usage of this valuable health care service. In addition, the fact that the copayment would not be applied to the first 20 home health visits will assure that individuals will not be deterred from early utilization of a health benefit that in many instances can prevent the need for costlier services at a later date.

MANDATED SECOND OPINIONS FOR SURGERY

A proposal calling for a mandatory second surgical opinion program (SSOP) for surgical services for Medicare beneficiaries has been receiving attention as a potential for program savings. The AMA recognizes that the advisability of surgery or other specific therapy can be a matter of opinion; however, we do not support mandating second opinions. The American Medical Association: (1) reaffirms the right of the patient or a physician to seek a second opinion freely from any

physician of choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by a third party payor for not obtaining a second opinion; and (3) supports the concept that when a second opinion is required by a third party that second opinion should be at no cost to the patient.

Voluntary second opinions are valuable for both the physician and the patient. Where either party voluntarily solicits a second opinion, the second opinion can help in establishing a direction for the course of treatment. Also, such an opinion may have the effect of saving money if it presents an alternative course of treatment which proves to be less expensive than the surgery initially considered. Finally, a second opinion can encourage a patient to have needed surgery when the patient might have reservations concerning the surgery or initially chooses against the surgery recommended by the first physician.

The AMA is opposed to mandated second opinions before every elective surgical procedure. Their imposition into the existing patient/physician relationship could have a deleterious effect on that relationship and it could impose an element of doubt in a patient's mind at a time when that patient is most in need of a strong belief in the views and abilities of his or her physician. Patients should be presented the option of seeking a second opinion for treatment decisions, instead of being automatically subjected to mandatory second opinions. We believe patients will be better served if the federal government encourages second opinions instead of requiring mandatory second opinions.

We also note that the potential for savings from mandating second opinions may be illusory. A July 1 report from the Congressional Budget

Office called estimated savings "very uncertain." The report went on to state:

Because no study has been done of the reductions in surgery rates in Medicare (or among the aged population) as a result of a mandatory SSOP, the SSOP's effects are largely speculative. It is possible that the costs of a SSOP could exceed any savings or that savings could be even higher than our estimates.

EXPANDED COVERAGE FOR THE SERVICES OF OPTOMETRISTS

The Medicare program authorizes Medicare coverage for optometric services only "with respect to services related to the condition of aphakia." Some proposals would expand this level of coverage to include virtually all services that an optometrist is authorized to perform by the state in which he or she practices.

The AMA is concerned with the prospect of adding additional expenses to the Medicare program at a time when efforts are underway to find ways to limit the program's expenses. The possible extent of such additional expenditures was detailed in a report submitted to Congress by the Secretary of HHS in 1982. The report says that "the costs associated with even a limited benefit expansion would be difficult to justify in the present economic climate." The following chart from the December 6, 1982, report represents the HCFA estimates of potential Medicare costs for coverage of optometrists' services:

<u>Fiscal Year</u>	<u>Services Related to Cataracts*</u>	<u>Other Services*</u>	<u>Total*</u>
1983	\$20	\$ 80	\$100
1984	30	100	130
1985	30	120	150
1986	40	130	170
1987	50	140	190

*Figures in millions of dollars.

ADMINISTRATIVE AND JUDICIAL REVIEW OF MEDICARE PART B DETERMINATIONS

Legislation has recently been introduced, H.R. 2864, to authorize both administrative and judicial review of questions arising over the amount of benefits permitted under Part B of Medicare. While the Medicare law has always authorized appeals over determinations made under the Part A segment of the Medicare program, such appeals have not been allowed for questions arising out of the Part B program. This long-standing inequity in the law should be corrected.

Since a Medicare beneficiary has no right to appeal a denial of benefits for Part B services under existing law, this inequity can result in beneficiaries and physicians who have accepted assignment having no recourse when coverage is denied.

ALTERNATIVE PHYSICIAN PAYMENT METHODOLOGIES

The AMA supports research and demonstration projects to examine various methodologies for physician reimbursement. Such projects and studies would be helpful in determining a fair and successful modification in how physicians are paid for their Medicare services. Without adequate study, rapid modification in payment could be detrimental to the goals of health care services of high quality and continued improvement in overall health status.

The AMA fully supports a pluralistic approach to payment for physician services. We believe that an indemnity payment system should be viewed as the preferred policy for setting physician reimbursement.

Physician Payments Based on Diagnosis Related Groups (DRG)

One methodology for physician reimbursement being studied is to base payment on a fixed cost based on the patient's diagnosis. This

concept is the focus of a Congressionally-mandated study by HHS. This study was due by July 1 of this year, but it has yet to be released.

Just as we have continuing concerns over the hospital DRG payment program, we have strong concerns with a DRG-based physician payment plan. A DRG system inherently gives substantial incentives to provide minimal care. It also fails to take into account severity of illness. This is especially troublesome for those physicians who because of specialized skill and training see patients with the most severe illnesses. Since the DRG methodology is based on "averages" and (unlike hospitals) individual physicians do not ordinarily have a large enough patient population with identical diagnoses to enable costs to be spread over a larger base, a DRG system could operate as a disincentive for physicians to accept critically ill Medicare patients and could discourage necessary use of consultants.

We are also concerned about a program where all services to hospital inpatients would be based on DRGs and payment would be made through the hospital. It is evident that if both hospital and physician payments are based on a predetermined amount, all of the economic incentives will be strongly directed toward under-provision of care.

Perhaps the most serious drawback to a DRG-based payment system is that it would break down the role of the physician as the health care advocate for the patient. We never want to see the day when the "best" physician (as designated by Medicare) would be said to be the one who was the least expensive as opposed to the one who provided the

best care. Because of its strong potential for adverse effects on patient care, we would object to a DRG system in the absence of proven demonstrations.

Relative Value Studies

The AMA is actively pursuing the development of a relative value study (RVS) to establish resource cost based relative values for physician services.

A reimbursement system based on a resource cost based relative value study could ameliorate problems inherent in current Medicare reimbursement, and it could allow for greater competition among physicians by allowing patients a greater understanding of charges made for each service. Such a system could also address inequities in payment rates for services that are predominantly cognitive in nature.

CONCLUSION

Medicare beneficiaries are entitled to high quality health care services. We are concerned that budget proposals will have an adverse impact on the ability of physicians, hospitals and others to assure Medicare beneficiaries the quality of services they were promised.

Mr. WAXMAN. Fine. Thank you very much.
Dr. Connally.

STATEMENT OF N. THOMAS CONNALLY, M.D.

Dr. CONNALLY. Thank you, Mr. Chairman.

I am Thomas Connally. I am an internist in private practice here in Washington and chairman of Governmental Activities for the American Society of Internal Medicine.

On April 26, the president of the ASIM, Burns Roehrig, testified before the subcommittee on the ramifications of the proposed Medicare freeze. He noted that during the 27 months of the currently proposed freeze, Medicare allowances will remain based on fees established by physicians in 1982 or earlier.

Since 1982, inflation as measured by the CPI will have increased at a cumulative rate of 17 percent. Surveys on overhead costs indicate that physicians' overhead costs have increased faster. In addition, he expressed concern about the quality of the entire Medicare Program with increased economic constraints on physicians.

In the ensuing months, ASIM has gathered increased data which make us feel that it is increasingly important for Congress to continue maintaining its commitment to physicians and patients, but this commitment should not be limited to the approximately 30 percent of physicians who have opted to accept Medicare assignments.

It is important to understand that physicians as healers and good citizens have honored their commitments to deliver high quality services to control costs and to remain sensitive to their patients' financial needs despite the economic burdens of the current freeze.

In 1983, ASIM first endorsed a voluntary 1-year freeze. The AMA followed suit a few months later. The vast majority of physicians voluntarily complied. I personally am now well into the third year of my freeze. I was in charge of the ASIM Program that started the freeze, and I felt that as long as I was encouraging it, I should go along with it; but now it is 3 years and another 15 months or so are proposed, and it is beginning to get a little tough.

In addition, as Dr. Carolyn Davis reported, we have seen that now Medicare assignment rate is reaching almost 70 percent. Some of this increase obviously has resulted from the participating physician program, but the vast majority of services continue to be provided by nonparticipating physicians. It is those participating physicians who have voluntarily chosen to accept assignment on a larger percentage of claims than at any other time in the past.

ASIM has recently surveyed its members through a mail campaign through our national newsletter, and the survey clearly is not scientific. It is what in medicine we call anecdotal evidence. But I think it is clear from this data, which we have given to committee, that there probably will be deterioration in the quality of the program and we will have a two-tiered service for Medicare patients and non-Medicare patients if the freeze keeps on indefinitely.

I certainly do not believe that Congress or the administration wants patients covered by Medicare to be treated as second class citizens, and certainly the medical profession does not want this to happen.

At ASIM we recognize, though, that in attempting to reduce the Federal deficits, Congress may decide to continue some kind of freeze on Medicare part B allowances. If this is the case, we once again urge the subcommittee to consider alternatives that are less likely to have a detrimental effect associated with an across-the-board freeze extension.

For example, Congress should consider allowing the prevailing and customary charges of both participating and nonparticipating physicians to increase for their office, nursing and home visits while maintaining the freeze on other services.

The outpatient primary care services and cognitive services that would be exempted from the freeze under the proposal are the ones that have traditionally been undervalued under the Medicare reimbursement system, and they are hit the hardest by an extension of the freeze. They are also the ones incurring the highest overhead costs for physicians.

By providing some release for these categories of service. Congress would take an important step toward ensuring that Medicare patients can continue to receive high quality care.

A selective freeze of this nature would begin to correct some of the imbalances in the current reimbursement system by reducing the current disparity between physicians' cognitive and procedural services, a long-term reform that certainly is needed.

The CBO has estimated that this option would save \$800 million during the next 3 years, an amount about comparable to what the proposal that has come from Ways and Means would save. It appears that there is a consensus throughout groups interested in this, including senior citizen groups and other medical groups, that this type of proposal is an important one, and I think one of the things it would answer for you, it would partially keep the promise made by Congress last year to both participating and nonparticipating physicians.

And finally, ASIM continues to strongly favor long-term changes in the physician reimbursement system that would make allowances more predictable both for physicians and patients as well as correct some of the inequities and imbalances in the current system.

We believe that HCFA should award a contract to develop a resource cost relative value system for physician services. Harvard University has submitted a proposal to HCFAR to accomplish just that. Such a resource-based system would provide a more rational method.

If you have any questions, I can answer them.

[The prepared statement of Dr. Connally follows:]

AMERICAN SOCIETY OF INTERNAL MEDICINE

JULY 1985

1 1. OVERVIEW
2

3 The American Society of Internal Medicine (ASIM) is a national medical association
4 comprised of physicians who specialize in internal medicine. ASIM recognizes the
5 seriousness of the federal budget deficit and the urgency it generates to create
6 policy to reduce and eventually eliminate the deficit. ASIM has reviewed the
7 President's FY 1986 budget and has provided Congress with several alternative
8 courses of action to revise the budget. The Society's recommendations--summarized
9 in its May, 1985 statement, The FY 1986 Budget: Analysis Recommendations and
10 Alternatives of the American Society of Internal Medicine--has been mailed to all
11 members of the Senate Finance Committee, House Energy and Commerce
12 Committee, House Ways and Means Committee, and House Budget Committee.
13 (Additional copies are available upon request.)
14

15 As noted in the May, 1985 statement, ASIM does not agree with a very important
16 aspect of the Reagan Administration's FY 1986 budget proposal: the provision to
17 extend for one year the current freeze on Medicare reimbursement for physicians'
18 services. The Society, after 20 years of experience with the Medicare program,
19 urges Congress to consider alternative means of moderating the expenditures on
20 Medicare Part B, including making structural reforms in the method by which
21 physicians' services are reimbursed under the program. Proposals for making long-
22 term changes in the physician reimbursement system--as well as for selective, short-
23 term freeze alternatives--are summarized in ASIM' statement on the proposed
24 budget. The statement also identifies several negative results that are likely to

occur from an extension of the current Medicare freeze, including the curtailment of services to beneficiaries, increased out-of-pocket expenses, increased Medicare expenditures over the long term, cost shifting to non-Medicare patients, and perpetuation of the current incentives for high cost technology.

In an effort to further document what is likely to occur if the freeze is extended, ASIM recently asked its 18,000 physician-members to share with us how they will react to a continuation of the freeze. Their responses demonstrate the disturbing implications of a one-year extension of the fee freeze in practical terms—told by the physicians themselves, as they explain what effects such a measure will have on their professional lives, as well as on the lives of their patients.

2. ASIM'S INQUIRY OF PHYSICIANS' ATTITUDES REGARDING AN EXTENDED FEE FREEZE

In the April 1985 Intercom, ASIM's monthly newsletter, ASIM asked internists to respond to the question: "If the across-the-board fee freeze is extended, what will be the likely effects on your practice?" Although not a scientific survey, the responses indicate the strong feelings from internists throughout the country. Seven themes were repeatedly expressed: services will be curtailed; physicians will have to lay off staff; out-of-pocket expenses for Medicare patients will increase; the availability of care to Medicare patients will decline; cost shifting will occur; fewer physicians will be inclined to participate; and more will retire early from practice.

1 3. RESULTS

2
3 A. CURTAILMENT OF SERVICES

4
5 Approximately twenty-eight percent (28.3%) of the internists who responded to
6 the survey believe that an extended freeze will result in the curtailment of
7 services, negatively affecting the quality of medical care. Because a
8 continuation of the freeze will result in Medicare reimbursements for FY 1985-
9 1986 being based on actual charges submitted during 1982 and thus, will not allow
10 for increases to reflect growing overhead costs, physicians must reduce costs and
11 services in order to remain financially viable. Between 1982 and 1983, practice
12 overhead increased 9.6 percent for all physicians and has continued to do so at a
13 steady rate. Practice overhead for those who specialize in internal medicine
14 increased 15.3 percent during that same period. (Source: Socioeconomic
15 Characteristics of Medical Practice, 1984 edition, Chicago, the American
16 Medical Association.) An internist from Binghamton, New York remarked:

17
18 "Overhead has already been cut to the bone in my practice. Further
19 reductions will immediately affect care; phone calls will not be
20 answered, forms not completed, information not transmitted
21 properly."

1 More specifically, of those who believe services will be curtailed, 17.7 percent
2 say they will offer or deliver fewer services; 12.5 percent will spend less time
3 per visit with their Medicare patients and thus, increase their patient load; 1.0
4 percent will cut hours, indirectly decreasing the amount of time spent with each
5 patient; 2.08 percent will not be able to purchase new or updated equipment; and
6 10.4 percent will have to directly reduce thoroughness and quality of their
7 services. An internist from Los Angeles, California, describes the situation that
8 he, as well as other specialists of internal medicine, finds himself in:

9
10 ". . . The problems with rising overhead cost and limited
11 reimbursement create strains on our own practice management. If
12 there is a persistence of the freeze. . . we will definitely curtail our
13 services and will have to possibly trim back certain aspects of our
14 practice.

15
16 The government and private industry should be aware that they do
17 wish us to become 'more businesslike,' and therefore, we would have
18 to treat the Medicare patients appropriately according to business
19 principles. Patients who result in lower levels of reimbursement will
20 get lower levels of care. To be good businessmen, we will have to
21 put our efforts in terms of diagnosis and treatment towards those
22 patient groups who result in a higher reimbursement for a given
23 service."

1 In response to the Intercom inquiry, many internists complained that the current
2 fee freeze, with its excess paper work and financial limitations, has already
3 made it more difficult to provide quality medical care, and that a prolonged
4 freeze will exacerbate this problem. Several reported that their accountants
5 have advised them to reduce either the quality or time of their services if the
6 freeze is extended. Others have indicated that they will terminate extra
7 services such as house calls--if they have not done so already--or will not
8 purchase more advanced equipment, which would enhance the quality of care and
9 even save patients' dollars in the long run. For example, an internist from
10 Lutherville, Maryland, said:

11
12 "If I cannot raise my office charges, I will also not get an office
13 spirometer, which means I will continue to rely on more expensive
14 hospital-based pulmonary labs."

15
16 Furthermore, a prolonged freeze on Medicare reimbursement will develop those
17 on Medicare into "second-class" patients. As the fee freeze maintains
18 reimbursement levels well below the level of inflation, non-Medicare patients
19 will take priority over Medicare patients, resulting in disparities in the quality of
20 services rendered to Medicare and non-Medicare persons. A Los Altos,
21 California, physician states that:

22
23 "if the Medicare freeze is extended, I will be forced to stratify my
24 care of Medicare recipients into fast-track--i.e., less customized,
25 'inferior'--care."

1 B. REDUCTION OF STAFF

2
3 A large portion of respondents (31.25 percent) feels that if the Medicare fee
4 freeze is extended, they will have to lay off employees or reduce the salaries or
5 hours of employees in order to maintain their practices. An extended freeze will
6 mean that physicians will have to take such measures to reduce overhead costs,
7 and "thus, add to the unemployment rolls" (as an internist from Houston, Texas,
8 phrased it). Staff cuts have serious implications concerning the quality of
9 medical care; the staff will be overworked, forced to cut corners order to
10 finish their duties, and be unable to provide individualized attention to patients.

11
12 C. INCREASED OUT-OF-POCKET EXPENSES AND REDUCED ACCESS TO
13 CARE FOR MEDICARE PATIENTS

14
15 Over forty-one percent (41.66%) percent of internists surveyed believe that out-
16 of-pocket expenses for Medicare patients will actually increase and access to
17 care for these patients will be reduced if the fee freeze is continued, as
18 physicians will be forced to accept fewer cases on assignment (30.2 percent), to
19 resort to "additional charging" (3.12 percent), and to refuse new Medicare
20 patients (14.58 percent). As the large percentage demonstrates, an extended
21 freeze with low reimbursement levels will discourage physicians from accepting
22 Medicare assignment. A physician from Wynnewood, Pennsylvania, states:

23
24 "Any fee freeze in the future will reduce my acceptance of
25 assignment. Medicine will fail to thrive under fee freezes."

1 Physicians also reported that they will have to resort to "additional charging,"
2 that is, charging for common procedures which they normally deliver free of
3 charge. An internist from Reno, Nevada, stated:
4

5 "To make up for the specific losses which are coming about from the
6 wage freeze, however, we are augmenting our fees. Many of the
7 things that have been done in our office at no charge are now being
8 charged. These are new services such as fingerstick blood glucose,
9 dipstick urinalysis, strep screen for sore throats, etc. In addition,
10 we are augmenting our fees for in-hospital services and adding
11 telephone charges."
12

13 As the Medicare fee freeze increases patient out-of-pocket expenditures, it will
14 continue to cause patient confusion. An internist from Anniston, Alabama, notes
15 that:
16

17 "Most elderly beneficiaries are therefore confused and angry when
18 asked to pay several months later after a service. There has also
19 been an increase in the number of services rendered to beneficiaries,
20 because if they don't have to pay anything at the time of service,
21 they would come into the office more often for less severe
22 problems, increasing the Medicare costs."

1 Many physicians will also decrease the number of Medicare patients in their
2 current patient load as well as refuse to see any new Medicare patients, reducing
3 the availability of care to Medicare patients. One internist from Muncie,
4 Indiana, stated his concern:

5
6 "I (had) to tell my receptionist to refuse the request of any
7 prospective new patient over the age of 60 who calls in asking to be
8 a patient of mine. I worry some that this may mean that Medicare
9 patients may find it difficult to locate doctors, just as Medicaid
10 patients have sometimes found in the past."

11
12 D. COST-SHIFTING

13
14 More than fifteen percent (15.62%) of the respondents said they will have to
15 compensate for the frozen Medicare fees by cost-shifting to non-Medicare
16 patients. Many feel that they will have to create two fee levels with a higher
17 fee for their non-Medicare patients. An internist from Eugene, Oregon explains
18 his situation:

19
20 "It therefore becomes obvious that we have to start raising our fees
21 for our private patients. This Robin Hood approach was what I
22 disliked when I came into practice back in 1963, and I have some
23 concern for the morality of this approach now. This is especially
24 grating when I see some of my private patients who have
25 considerably fewer resources than my retirees from the wood
26 products industry and the California corporations."

1 Non-Medicare patients will be forced to subsidize physician losses from the
2 freeze through two-tiered fee standards, regardless of their financial ability.

3
4 E. DISINCENTIVE TO PARTICIPATE

5
6 Those physicians who have agreed to "participate" are also becoming disillusioned
7 with the program. "Participating" physicians find it especially difficult to
8 maintain their practices with inadequate reimbursement levels and delayed
9 payments, since they do not have the choice to refuse assignment on Medicare
10 patients. One troubled internist from Alabama expressing his disapproval:

11
12 "I am unfortunately a 'participating physician' and over the past six
13 months the local intermediary has denied or underpaid, according to
14 UCR schedules, my claims by nearly \$1,500. This is above and
15 beyond the average of 47 percent that I have to write off based upon
16 the UCR 'allowable'. Many of these disallowed claims are on
17 patients who are switching to me as a 'participating physician.' The
18 fact that payment to me is denied, destroys the intent of the AARP
19 and Congress trying to encourage patients to use participators. . . I
20 hope I can be 'counted out' of the 'participating' category as soon as
21 possible. I do think the failure to pay \$1,500 for services actually
22 rendered but disallowed (or decreased from a UCR by often more
23 than 75 percent) is a breach of contract."

24
25 Over eighty-seven percent (87.5%) of those participating physicians who
26 responded to the survey feel that they will have to become "non-participating"
27 physicians in October 1985.

F. EARLY RETIREMENT

Approximately eight percent (8.3%) of responding internists stated that a continuation of the Medicare fee freeze will force them into early retirement from medical practice; of these, some will have to retire from their practice three to five years earlier than they had planned, and others will have to pursue another occupation as they are not near retirement age. This will tend to prematurely disrupt established doctor-patient relationships and may create access problems for some Medicare beneficiaries.

4. CONCLUSION

Physicians took the time to respond to our survey to document exactly what an extended fee freeze would mean to them. Medicare patients will receive a lesser quality of care as physicians are forced to curtail their services, decrease their staff, and reduce the thoroughness of their care.

Medicare patients will find themselves classified as "second-class" patients and will pay more out-of-pocket expenses as "non-participating" physicians are pressed to decrease the number of patients for whom they accept assignment. Private patients will find that their medical costs will increase as they become subsidizers for Medicare patients. Those physicians who have agreed to participate will lose faith in the Medicare program and will not renew their participation agreements. Finally, some physicians will be discouraged from even continuing to practice medicine. An extension of the freeze on allowances for physician services will hurt more people than it will help. The American Society of Internal Medicine urges Congress to reject the Administration's proposal to extend the freeze, and to consider other measures, such as freezing: all services except those that are solely cognitive in nature (such as consultations and office, nursing home and hospital visits); only those higher-cost services with prevailing charges over a certain specified dollar level; or only Part B (physician) services rendered to hospital inpatients.

Mr. WAXMAN. The Senate has passed a budget. The House has passed a budget. Both call for deep cuts in Medicare. The only way we can get deep cuts in Medicare is either to ask the patients to pay more through their premiums and deductibles and coinsurance or limit the amounts that it will pay in terms of increases for hospitals. We have a freeze already in place, and of course the Senate and the administration has proposed to continue this freeze.

Do you think, in response to this, we should just ignore the requirement that is suggested be placed on us to reduce the spending in Medicare, or would you have some other suggestion as to how we can come up with a saving factor?

Dr. SCHENKEN. As a citizen and as a physician, I certainly would not advise you to ignore the problems that we have budgetary and tax-wise. I would advise you to address them. Our problem is that we do not think that those cuts and those budget deficits should be balanced on the backs of Medicare. We are in favor of an across-the-board freeze on everything. That would treat everybody the same. We won't like it but we will go along with it.

To focus on one particular segment, the Medicare program is unfair. Historically, selective wage and price freezes, which this is under the program, have really given trouble either going in or coming out.

Mr. WAXMAN. How do we achieve less Government spending in the Medicare area if we don't put a freeze on physicians? We can put a freeze on physicians and hospitals, and the administration has recommended doing both of those, and a freeze on other provider payments. If we do not accomplish the savings in that way, how else are we going to save money in the Medicare problem?

Dr. SCHENKEN. We are in the process of doing some things which both the profession and the Congress agree on, such as moving from inpatient surgery to outpatient surgery, moving toward the development of a rational relative value schedule, and moving toward more office care rather than hospital care. While we are doing a lot of those types of actions, I am afraid that what you are about to do is to break faith with the doctors in the interim for a proposal which everybody agrees is really just a 1-year stalling action.

I heard three or four previous witnesses say that they don't like the freeze but we are just trying to get from here to there. We think that the damage done by the freeze is going to be worse than to try to address these things as soon as we can through rational programs.

Mr. WAXMAN. It is clearly a stalling action. A representative of the administration, Dr. Davis, just told us a minute ago she does not consider this reform of the health care system but it saves a lot of money in that 1-year time, and we have got a big budget deficit. Both Budget Committees have told us to save money in Medicare, which is a big spending item for the Federal program.

I guess that is the dilemma we have, and if you have some other thoughts for us, we will be glad to receive them. The ASIM suggestion, which we also received from AARP, which would exempt office, nursing home and home visits from the freeze, has some appeal. We also heard concerns that it would make the rules much

more complex to understand and administer and it would undermine the incentive to sign up and be a participating physician.

What response do both of you have to that?

Dr. CONNALLY. I'm not sure how much more complicated it would make Dr. Davis' administration. I don't think it would be so difficult in the physician's office. If things are not difficult for our billing system, they are not usually so difficult for the intermediaries. All they have got to do is take those dozen or 15 or 17 items that are that many out of the many hundreds of CPT codes and say these you may increase or we will increase the allowance for these and you may increase your charges for these, up to 4 percent or whatever it would be.

I think it would be a simple thing to do. The letter could go to the doctor and you would say this number, this number and this number may be increased. I don't think it would be that difficult, the relationship between the Medicare intermediaries and the physicians. I don't think it would be that difficult.

Mr. WAXMAN. What do you think, Dr. Schenken? Do you think that we ought to have not an across-the-board freeze, but if we have to have a freeze, have some kind of moving forward of health care policy by selective freezes?

Dr. SCHENKEN. I cannot believe it is going to be that complex. It does not look that complex to me in terms of the negative incentive to take the assignment. I would think it would be just the opposite. We already have 69 percent of the claims assigned for a variety of reasons, including low incomes, competition, all sorts of things, and this would be an incentive for providing care where most doctors have thought it should be in the first place.

The issue, though, is fairness, and the point raised by ASIM is proper. Office visit fee profiles around the Nation are low. They are unfortunately so low that office-based physicians are often looking at other sources of income to make up for these low fees. From the fairness aspect we would agree with that. We just think that the rest of the doctors need some fairness, too.

Mr. WAXMAN. Let me ask you this. If you had a choice between selective freezes on the highest paid profiles for some doctors and no freezes for some of these items like office visits, home visits and so on and so forth, where some argue there is undervaluation of them—if you had a choice between selective freezes and across-the-board freezes, what would you take? Not that you like either of those as your first choices.

Dr. SCHENKEN. The association has not taken a position on that, but answering it personally, if I was absolutely sure that those were the only two options, I would sure like to help the people in the office if I could.

Mr. CONNALLY. The long-range reform—I think this is one of the things certainly that almost everybody, including Dr. Davis, is talking about to try to somehow correct the disparity between reimbursement for the cognitive office-based services as opposed to the surgical and laboratory services.

Dr. SCHENKEN. One further comment, Mr. Chairman. I would sure hate to see something like that happen and then not in a short period of time, have a move to an RVS or something that

treats all of the profession fairly. Because, you talk about a loss of faith, that would really be a governmental loss of faith.

Mr. WAXMAN. Another idea under discussion is to establish a commission to make recommendations on payments for physicians. The commission would try to study how we move to reform the system. Do you have comments on the notion as to the structure and its assigned duties?

Dr. SCHENKEN. We're not sure it is necessary. There are a variety of other commissions, like OTA, that are already studying it. We have no problem with it, if it was properly based to be broadly representative of the profession.

Mr. CONNALLY. It probably would not be necessary and that HCFA could get some group to do it. If the Congress or your committee felt that it was absolutely necessary, I think it would be most appropriate to have—since it is working with relative values of payments and reimbursement, how doctors are reimbursed, I think that you would want to have a group that was predominantly composed of physicians with all specialties, and subspecialties represented, with some insurance people, a few of the academicians who have had some experience in this area, and then maybe some consumer representatives. I think it would be mostly doctors.

Mr. WHITTAKER. I would like to ask a modification of your question, posed a little different way. What if, hypothetically—and either one of you may answer this—the options were to either freeze these for all physicians or freeze these for the nonparticipating physicians? Which would you then prefer?

Dr. SCHENKEN. We think fairness is an important issue, and I think we're all in this together. I don't like either one of those options. If you're going to force a freeze, we would prefer it to be on everybody because then the profession will be faced with the same problems.

Mr. WHITTAKER. Participating and nonparticipating?

Dr. SCHENKEN. There is a myth over the concept of participating and nonparticipating. That is a definitional problem. We have 60 percent or almost 70 percent of the benefits provided on an assigned basis. That means that most physicians are substantially participating physicians. Actually, 23 percent of physicians who reported to us that they were taking 100 percent of their claims on an assigned basis did not sign up as participating physicians because of philosophical reasons. We can't substantiate that reason for not participating, but those figures are about right.

So no, I think it is really wrong to discriminate between participating and nonparticipating because the people that are technically nonparticipating are, in fact, taking large numbers of assignments from needy and other beneficiaries.

Mr. CONNALLY. I am not a participator but have been increasing by a great percentage the numbers of patients on whom I am accepting assignment in the last year and a half or so. And I would be upset by not having that recognized.

Mr. WHITTAKER. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. One short one, Mr. Chairman. Assuming, Dr. Schenken, that there are no very good options. Many of us in this com-

mittee have been round and round here and with, physicians at home. I am convinced that there are not any very ideal options.

Given that, would you say that the mandatory second opinion is the least onerous of what is on the table? The least burdensome? Having stipulated the fact that you don't like any of them, and I think you have made that clear, I would be interested in knowing, because I know the AMA has encouraged it voluntarily, whether this would be the least burdensome of what is on the table.

Dr. SCHENKEN. Other than the ones that we have supported, including your bill which we do not consider onerous, I would answer that yes.

Mr. WYDEN. Thank you.

Dr. SCHENKEN. Could I comment on one of your statements? You said considering that there are no good options.

I would like to state that we do have a committee within the AMA studying long-term options for Medicare. We have provided the committee with reports in the past and we anticipate either this fall or next spring to have a substantial proposal which we think will have some valid directions for the future. We would like to be able to provide it to the chairman and to the rest of you for your review.

Mr. WYDEN. That is a fair comment. I only made it in the sense that when I get together at home with physicians and the Gray Panthers, we always walk away saying gee, there are really not any ideal choices here. So we're basically saying which of these things that are not appealing to any of us are we going to look at. And that's why I asked.

Dr. SCHENKEN. It's like the coach saying, "Mr. Wyden, guard Abdul Jabbar." It's not a very easy thing to do.

Mr. WYDEN. As a former basketball player, I know when I'm in over my head.

Mr. WAXMAN. Suppose we said that we would have a freeze in effect, but for each bill where assignment was taken, there would not be a freeze. In other words, then, take assignment under all circumstances; for each time you take a Medicare, you bill Medicare, and you have taken assignment we would lift the freeze.

Mr. CONNALLY. I would not object to that if you can administer it. It sounds like if there is going to be an administrative problem that would be a more difficult one.

Mr. WAXMAN. The question is, did the physician take assignment, yes or no. If the physician did, you give one fee level; if he didn't, you give another.

Dr. SCHENKEN. Can I get back to you? My first blush is that such a policy would have massive operational problems.

Mr. WAXMAN. We will be pleased to hear from you further on it.

Dr. SCHENKEN. We have not addressed that in the association and I would like, Mr. Chairman, to get back to you.

Mr. WAXMAN. Thank you both for your testimony today. We appreciate it.

For our next panel we would like to call Dr. David Ferris, American Optometric Association and Dr. Thomas Frey, associate secretary of the Federal Legislation of the American Academy of Ophthalmology.

Both of your statements will be part of the record, but first, our colleague Congress woman Mikulski would like to have her statement entered into the record at this time.

OPENING STATEMENT OF HON. BARBARA MIKULSKI

Mr. Chairman, thank you for convening this hearing to address important issues regarding the Medicare system. I am pleased to have this opportunity to speak in support of legislation I have introduced to bring equity to Medicare laws concerning vision care.

The Medicare Vision Reform Act, H.R. 2342, would reimburse beneficiaries for currently covered vision services when provided by any practitioner licensed under State law to render these services. My bill is not an expansion of Medicare-covered services. Rather, I seek to ensure that Medicare-eligible patients are treated fairly in obtaining eye and vision care.

Currently, with the exception of post-cataract patients, beneficiaries who choose a doctor of optometry for care are forced to pay out-of-pocket for services that Medicare covers when provided by an ophthalmologist. This is patently unfair to beneficiaries and clearly inconsistent with the intent of the Medicare Program.

H.R. 2342 has attracted bipartisan support from 67 cosponsors. Among these cosponsors are over half of my colleagues here on the Health Subcommittee. This bill has also garnered endorsements from numerous organizations including: The American Association of Retired Persons, the American Public Health Association, the National Council on Aging, and the National Association of Hispanic Elderly.

I have received letters from ophthalmologists and optometrists around the country highlighting the need for H.R. 2342. In one of these letters, Dr. C. Richard Epes, an ophthalmologist with the Southeastern Eye Center, notes that "the time has long since passed for arguing that optometrists are somehow not qualified to provide these services . . . the patients I see in my practice who have been referred by optometrists are testimony to the high level of care being provided to them by doctors of optometry."

Mr. Chairman, the input provided by the endorsing organizations and ophthalmologists from around the country are an important contribution to our consideration of H.R. 2342. Without objection I ask that several of these letters be included in the hearing record.

Today we are considering various deficit reduction proposals affecting Medicare part B. I share with my colleagues a deep concern over our growing Federal deficit and the need to contain costs. I believe that the cost of H.R. 2342 is consistent with our budget targets. The Congressional Budget Office estimates that in fiscal year 1986, H.R. 2342 would cost the Medicare program \$10 million. If a common fee screen of optometrists and ophthalmologists is not used, CBO estimates the cost to be \$20 million. This minimal cost is well worth the benefits H.R. 2342 will provide to Medicare-eligible patients.

Mr. Chairman, I commend your leadership in the area of Medicare reform and thank you for your fine work in behalf of Medicare beneficiaries. I believe that H.R. 2342 will greatly improve health care coverage for older Americans and reduce their growing out-of-pocket health expenses. Let me reiterate that my bill does not add any new services to the Medicare Program, nor does it regulate which services may be performed by an optometrist. Rather, it provides parity and access to patients consistent with Medicare rules and State licensing laws. I look forward to hearing the testimony on this important issue.

STATEMENTS OF DAVID W. FERRIS, PRESIDENT-ELECT, AMERICAN OPTOMETRIC ASSOCIATION; AND THOMAS FREY, ON BEHALF OF AMERICAN ACADEMY OF OPHTHALMOLOGY

Mr. FERRIS. Mr. Chairman, my name is David Ferris, I am a practicing doctor of optometry. I appreciate the opportunity to appear before you today to express our strong support for H.R. 2342, introduced by Hon. Barbara Mikulski and cosponsored by over half of her colleagues on the subcommittee. H.R. 2342 would address a major inequity in the Medicare program by reimbursing presently covered eye/vision services under Medicare when provid-

ed by any practitioner licensed under State law to provide those services.

With the exception of post-cataract patients, Medicare beneficiaries who currently seek care from doctors of optometry cannot be reimbursed by the program, even though the same services would be reimbursed if provided by a doctor of medicine or osteopathy, whether or not they specialize in diseases of the eye.

These patients are faced with three equally undesirable choices; one, personally pay for the services from limited incomes; two, go without care altogether; or three, switch from their chosen provider to an unknown one. Further, the last choice is not always feasible. Over a third of the Nation's counties have optometrists in practice but no M.D. eye specialists.

It is important to note that amending Medicare by H.R. 2342 does not add any new services under the program. The services are already covered. What the bill would do is assure that all beneficiaries are treated equally in obtaining these covered services.

In addition to addressing Medicare beneficiary discrimination, H.R. 2342 seeks to minimize the cost of the program by combining the customary fees of all the providers for these same eye care services into a single fee screen for determining Medicare prevailing services. Currently, Medicare calculates prevailing rates separately for optometrists and medical doctors, and the result is a higher prevailing rate for medical doctors since optometrist charges are generally less for the same service.

This concept is entirely consistent with the Health Care Financing Administration policy and various court decisions.

H.R. 2342 also addresses the growing difference between what Medicare recognizes as a reasonable charge for eye/vision services and the charge actually billed to the patient by mandating that all eye care providers accept assignment for ambulatory eye services. As far as I know, we are the only provider group to encourage its members to sign up for the participating physician program enacted last year, and we have the greatest provider percentage rate of any group.

Incidentally, competition in the eye care field would be enhanced considerably by including optometrists as full providers in the Medicare law.

Mr. Chairman, the cost for correcting this inequity is minimal. The Congressional Budget Office estimates H.R. 2342 would cost the program \$10 million in 1986. Further, if all Medicare beneficiaries had access to physicians, as some have suggested, and were willing to change from optometrists, the total cost of the program would then exceed the costs of this proposal.

Mr. Chairman, it is important to note that patients in other Federal programs are not faced with this problem. These programs either guarantee freedom of choice of practitioners, or have no restrictions on the use of eye care providers. They include Medicaid, most federally-qualified HMO's, Federal employees and military dependents.

Enactment of H.R. 2342 would be a long overdue fulfillment of the freedom-of-choice policy under Medicare set forth in the opening section. It would also be consistent with a recent U.S. Fifth Circuit Court of Appeals decision on Medicaid in Louisiana which

ruled that optometrists who perform eye care services that are within the scope of optometric practice shall be reimbursed to the same extent and under the same standards as physician providers.

Mr. Chairman, I would like to emphasize strongly that this is not a question of turf, of what provider group is qualified to provide what service. That is a question that is properly left to the States and the States have answered it long ago by granting doctors of optometry the right to provide services now covered under Medicare.

H.R. 2342 simply makes these services available to all beneficiaries on an equitable basis. This is truly a beneficiary bill, as evidenced by its endorsement by various groups such as the American Association of Retired Persons, the American Public Health Association, the National Association of Hispanic Elderly and the National Alliance of Senior Citizens and the National Council on Aging.

In 1980, Congress recognized the professional qualifications of doctors of optometry when they made their services available to those Medicare patients who had had cataract surgery. We believe the time is long past due to treat all Medicare beneficiaries equally, and we would urge this subcommittee to include H.R. 2342 in its Medicare reconciliation package.

Thank you for the opportunity to address the subcommittee, Mr. Chairman, I would be happy to answer your questions.

[The prepared statement of Mr. Ferris follows:]

TESTIMONY OF THE
AMERICAN OPTOMETRIC ASSOCIATION

Mr. Chairman, my name is David Ferris, and I am a practicing doctor of optometry from Warwick, Rhode Island and the President-Elect of the American Optometric Association.

I appreciate the opportunity to appear before you today to express AOA's strong support for H.R. 2342, introduced by the Honorable Barbara Mikulski and cosponsored by over half of her colleagues on the subcommittee.

H.R. 2342 would address a major inequity in the Medicare program by reimbursing presently covered eye/vision services under Medicare when provided by any practitioner licensed under state law to provide the services.

With the exception of post-cataract patients (those who have had the natural lens of the eye removed by surgery), Medicare beneficiaries who currently seek care from a doctor of optometry cannot be reimbursed by the program, even though the same services would be reimbursed if provided by any doctor of medicine or osteopathy, whether or not they specialize in diseases of the eye. Non-aphakic patients are faced with three equally undesirable choices: 1) personally pay for the services from limited incomes, 2) go without care altogether, or 3) switch from their chosen provider to an unknown one. Further, the last choice is not always feasible because of the lesser accessibility of ophthalmologists as compared with optometrists. Over a third of the nation's counties have optometrists in practice but no MD eye specialists

It is important to note that amending Medicare by H.R. 2342 does not add any new services under the program. The services are already covered. What the bill would do is assure that all beneficiaries are treated equitably in obtaining these covered services. I have attached to my statement a table

from a 1976 report by the Department of Health, Education and Welfare listing Medicare covered services which are within the scope of practice of and provided by both ophthalmologists and optometrists and their reimbursement status at that time (attachment 1). The only difference is that Medicare will reimburse patients, other than aphakic patients, who obtain the services from doctors of medicine or osteopathy but not those who obtain them from doctors of optometry.

In addition to addressing Medicare beneficiary discrimination, H.R. 2342 seeks to minimize the cost to the program by combining the customary fees of all providers for these same eye care services into a single fee screen for determining Medicare prevailing charges. Currently, Medicare calculates prevailing rates separately for optometrists and medical doctors. The result is a higher prevailing rate for medical doctors since optometrist charges are less for the same services. Under the provisions of H.R. 2342, some fees of all types of eye care providers would be reduced, and the new single prevailing rate would result in lower costs than would otherwise be the case.

This concept is entirely consistent with the Health Care Financing Administration (HCFA) policy and various Court Decisions requiring the use of identical codes for covered services whether provided by a medical doctor, doctor of osteopathy, or doctor of optometry.

H.R. 2342 also addresses the growing difference between what Medicare recognizes as the reasonable charge for eye/vision services and the charge actually billed to the patient by mandating that all eye care providers accept assignment for ambulatory eye services. This is a question the Congress has wrestled with in the past and it is one that has caused concern in the

provider community. Let me just say that the AOA endorses this concept. As far as I know, we are the only provider group to encourage its members to sign up for the participating physician program enacted last year and we have the greatest provider participation rate of any group. It is our belief that because of the competitive nature of the eye care field, mandating assignment for eye care providers will not result in substantial accessibility problems, a concern expressed by some. Incidentally, competition in the eye care field would be enhanced considerably by including optometrists as full providers in the Medicare law.

Mr. Chairman, the cost for correcting this inequity is minimal. The Congressional Budget Office estimates H.R. 2342 would cost the program \$10 million in 1986. If a common fee screen is not used, CBO estimates the costs to be \$20 million. Further, if all Medicare beneficiaries had access to physicians, as some have suggested, and were willing to change from optometrists, the total cost to the program would then exceed the costs of this proposal.

Mr. Chairman, it is important to note that patients in other federal programs are not faced with this problem. These programs either guarantee freedom-of-choice of practitioner or have no restrictions on the use of eye care providers. For example:

- Under Medicaid, most eye examinations, including eye health exams, are provided by optometrists.
- Most federally qualified HMO's utilize doctors of optometry, typically in a primary care role.
- Federal employees and military dependents are guaranteed the ability to select optometrists for covered eye benefits. In fact, just last year Congress extended the vision care benefit under CHAMPUS without any distinction made between optometrists and physicians as providers.

Enactment of H.R. 2342 would be a long overdue fulfillment of the freedom-of-choice policy under Medicare, set forth in its opening section as follows:

"Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services."

It would also be consistent with a recent U.S. 5th Circuit Court of Appeals decision on the Title XIX Medical Assistance Program (Medicaid) in Louisiana, which ruled that optometrists who perform eye care services that are within the scope of optometric practice shall be reimbursed to the same extent and under the same standards as physician providers who perform those same eye care services (Attachment 2).

Mr. Chairman, I would like to emphasize strongly that this is not a question of "turf," of what provider group is qualified to provide what services. That is a question that is properly left to the states, and the states have answered it long ago by granting doctors of optometry the right to provide services covered under Medicare. H.R. 2342 simply makes these services available to all beneficiaries on an equitable basis. This is truly a beneficiary bill, as evidenced by its endorsement by various groups such as the American Association of Retired Persons, the American Public Health Association, the National Association of Hispanic Elderly and the National Alliance of Senior Citizens.

In 1980, Congress recognized the professional qualifications of doctors of optometry when it made their services available to those Medicare patients who have had cataract surgery. We believe the time is long past due to treat all Medicare beneficiaries equally and we would urge the subcommittee to include H.R. 2342 in its Medicare reconciliation package.

Thank you for the opportunity to address the subcommittee, Mr. Chairman. I would be happy to answer any questions.

(3) services in connection with the provision of both temporary and permanent prosthetic lenses, including fitting and providing the lenses themselves. The only services for which optometrists may be reimbursed are dispensing services in connection with the actual fitting and provision of prosthetic lenses. Table 1 delineates the status of Part B reimbursement for services within the scope of practice of both physicians and optometrists.

TABLE 1

Part B Reimbursement Status of Services to Cataract and Aphakic Patients which are Provided by both Physicians and Optometrists

<u>Service*</u>	<u>Eligible for Part B Reimbursement Under Certain Conditions</u>	
	<u>MD/DO**</u>	<u>OD</u>
Personal and Family Health History,		
Symptoms and Vision Requirements	X	
Visual acuity - distance and near, with		
and without correction	X	
External examination (eye and adjacent structures)	X	
Direct and indirect ophthalmoscopy	X	
Biomicroscopy	X	
Tonometry	X	
Central and peripheral visual fields	X	
Ophthalmometry/Keratometry	X	
Refraction - objective and subjective,		
distance and near		
Ocular motility and binocular function	X	
Visual perception, color vision, Stereopsis, motor	X	
Evaluation for contact lenses	X	
Evaluation for low vision aids	X	
Evaluation for vision training therapy	X	
Ophthalmic prosthesis and services	X	X

* Services listed include only those within the scope of practice of both physicians and optometrists. All of the listed services would not necessarily be provided by either provider to every cataract or aphakic patient during the course of each examination.

** Most of these services, when provided by physicians, are typically provided only by those specializing in Ophthalmology. However, any doctor of medicine or osteopathy is authorized to carry out any of the services listed and could be reimbursed for any covered services provided.



W. W. EDWARDS
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF FAMILY SECURITY
755 RIVERSIDE NORTH

P. O. BOX 44085 - PHONE - 504 342-5472
BATON ROUGE, LOUISIANA 70804

February 11, 1985

ATTACHMENT 2

SANDRA L. ROBINSON, M.D.
SECRETARY
STATE HEALTH OFFICER
384045-6711

TO: Optometrists Enrolled in the Title XIX Medical Assistance Program

RE: Optometric Services

Effective for services rendered October 29, 1984, and thereafter the Medical Assistance Program revised its program for eye care services coverage. Optometrists who perform eye care services that are within the scope of optometric practice will be reimbursed to the same extent and according to the same standards as physician providers who perform those same eye care services. This policy change was implemented in accordance with the judgment of the U. S. Court of Appeals, 5th Circuit, in the case of Sandefur vs Cherry, rendered on October 29, 1984.

The program policy regarding service limits, exclusions, and reimbursement methodology that applies to physicians participating in the program will likewise apply to optometrist providers. The necessary program and claim processing changes have been completed, and optometrists can begin billing immediately for covered services performed on or after October 29, 1984.

Optometrists are to bill on the HCFA 1500 professional services claim form using CPT-4 procedure codes and ICD-9-CM diagnosis codes.

The Louisiana State Board of Optometry Examiners has certified the following CPT-4 codes to be within the scope of Optometric practice in Louisiana. Therefore, in accordance with the court order, the following CPT-4 codes are approved for program coverage when rendered by optometrists:

90000	90600	92012	92226
90010	90605	92014	92250
90015	90610	92020	92260
90017	90620	92060	92275
90020	90630	92065	92280
90030	90640	92081	92283
90040	90641	92082	92284
90050	90642	92083	92285
90060	90643	92100	
90070	92002	92140	
90080	92004	92225	

Descriptions of the above codes and explanations for appropriate use in billing can be found in the CPT-4 Procedure Code Book.

Optometrists are to discontinue billing state assigned procedure code 00014 and 00015 effective February 15, 1985.

Provider reimbursement for eye care services provided by optometrists and physicians are subject to the requirements and limits listed below:

1. Examination and/or treatment of an eye condition other than refractive error.
2. Refractions following cataract surgery.

NOTE: This service is available to all eligible recipients.

3. Routine eye examinations for EPSOT eligible recipients under age 21.

NOTE: Routine eye exams are allowed only for EPSOT eligible recipients under age 21.

4. Regular eyeglasses or contact lenses for EPSOT eligible recipients under age 21.
5. Cataract glasses or contact lenses following cataract surgery are limited to one permanent pair with the exception of EPSOT eligible recipients under age 21.

The PROFESSIONAL SERVICES provider manual is being revised to reflect the above program changes. Providers will be sent these revisions under separate cover by SDC, the fiscal intermediary.

If you have any questions regarding this change, please contact the Physician Program at (504) 342-6472.

Sincerely,

Marjorie T. Stewart

Marjorie T. Stewart
Assistant Secretary

Mr. WAXMAN. Thank you very much. We are pleased to hear your testimony.

Dr. Frey.

STATEMENT OF THOMAS FREY

Mr. FREY. My name is Thomas Frey, I am an ophthalmologist in private practice in Falls Church, VA. I appreciate the opportunity to testify today on behalf of the American Academy of Ophthalmology, representing 13,500 or 90 percent of the country's ophthalmologists; medical doctors who specialize in all phases of medical eye care.

We wish to express our opposition to H.R. 2342. As far as costs are concerned, this bill will significantly increase Medicare costs by at least \$100 million in the first year and \$190 million annually by the fifth year, according to Health Financing Administration actuaries.

Because of these costs, the Department of HHS recommended against the expansion of optometric services under Medicare in its recent report to Congress.

H.R. 2342 would attempt to reduce Medicare spending through a statutory requirement that optometrists' and ophthalmologists' charges be combined to establish a single fee profile for those services performed by those practitioners. In other words, the ophthalmologist's fee for an office visit would be reduced and the optometrist's raised to some midpoint, as indeed would the fee for the family doctor, the internists, who in fact care for many eye complaints in our Nation's elderly.

There are two fallacies at least that we see in this approach. First, the services are not comparable qualitatively; an ophthalmologist is a doctor of medicine who is trained and licensed to perform comprehensive medical and surgical treatment, while the optometrist is restricted by State license generally to the detection of eye conditions and prescription of corrective lenses. If the optometrist suspects the presence of an eye disease, the patient is referred to an ophthalmologist. The reason Medicare does not cover optometric services now is because they are routine screening procedures. Such exams are not covered for any medical or health discipline except as optional services by some HMO's.

There are twice as many optometrists as ophthalmologists. Hence, whatever savings might be achieved by reducing ophthalmologists' office visit fees are more than offset by the number of optometrists who would begin billing for office visits. In essence, there would be three times the number of eye practitioners reimbursed than there are now.

The HHS report noted, and I quote, that "the assumptions that there would be no increase in utilization of services and no duplication of services * * * we believe are probably erroneous."

As far as access is concerned, the proponents of H.R. 2342 claim that eye/vision care is not accessible. This is based on data at least a decade old. Today, less than 1 percent of the U.S. population is more than an hour's drive from an ophthalmologist. This is documented in the academy's ophthalmology manpower study based on Zip Code distribution. Ophthalmologists are practicing throughout

the country in inner city urban areas, rural areas and in alternative settings.

Senior citizens have convenient access to the comprehensive medical and surgical eye care provided by ophthalmologists. We concluded that data did not show that a significant number of beneficiaries are going without eye care services, and hence the costs of further extending the coverage of optometrists' services does not seem justified.

Proponents of H.R. 2342 claim that optometrists' services are the same as ophthalmologists. We urge this committee to consider the significant differences between the two. First, an optometrist, a doctor of optometry, is not a medical doctor. Optometrists are primarily trained in the visual functioning of the eye and in prescribing and fitting lenses and correcting focusing problems.

We study not only the visual function of the eye but its function as a vital organ of the body, its neurologic, vascular, metabolic functions. We study the healthy eye and the treatment of eye diseases and conditions which cannot be corrected with lenses. An optometrist attends 4 years, and before being licensed, can perform routine eye exams for about 300 persons. Only about 5 percent of all optometrists participate in an optometry residency program for the duration of a year or less.

All practicing ophthalmologists attend 4 years of medical school, a year of internship, 3 to 4 years of residency in ophthalmology, during which time they see probably about 15,000 patients.

The differences in services provided by optometrists and ophthalmologists stem from these differences in training. The differences are cognitive. The examination and diagnosis made by an ophthalmologist is a more complex cognitive process than services provided by an optometrist.

For these reasons, we urge the committee to reject H.R. 2342. It is too costly, adding \$100 million or more in the first year. It tends to equate two different groups of providers into one fee structure. It singles out a few providers from mandatory assignment. Its proponents claim it rectifies a problem of access when indeed there does not appear to be a problem of access, and indeed, this committee is grappling with the issue of oversupply of physicians, specialists such as ophthalmologists, in its consideration of grassroots medical proposals.

We thank you very much, and we will be submitting some more material to you.

[Testimony resumes on p. 574.]

[The prepared statement of Mr. Frey follows:]

American Academy of Ophthalmology

My name is Thomas Frey, and I am an ophthalmologist in private practice in Falls Church, Virginia. I appreciate this opportunity to testify today on behalf of the American Academy of Ophthalmology, representing 13,500 or 90 percent of the country's ophthalmologists - medical doctors who specialize in all phases of medical eye care.

We wish to express our opposition to HR 2342, the "Medicare Vision Reform Act of 1985." The proponents of this bill claim that it will provide budget savings, while increasing access to care and decreasing out-of-pocket expenses for Medicare beneficiaries. The Academy believes that these claims are based on unsubstantiated data.

Projected Cost. This bill will significantly increase Medicare costs by at least \$100 million in the first year, and \$190 million annually by the fifth year, according to Health Care Financing Administration actuaries. Because of these costs, the Department of Health and Human Services recommended against the expansion of optometric services under Medicare, in its recent report to Congress (see Attachment A).

HR 2342 would attempt to reduce Medicare spending through a statutory requirement that optometrists and ophthalmologists

charges be combined to establish a single fee "profile" for those services performed by both practitioners. In other words, the ophthalmologist's fee for an office visit would be reduced and optometrists' raised to some mid-point.

There are two fallacies in this approach: First, the services are not comparable qualitatively--an ophthalmologist is a doctor of medicine who is trained and licensed to perform comprehensive medical and surgical treatment, while the optometrist is restricted by state license generally to the detection of eye conditions, and prescription of corrective lenses. Then, if the optometrist suspects the presence of an eye disease, the patient must be referred to an ophthalmologist. The reason Medicare does not now cover optometric services is because they are routine screening procedures - such exams are not covered for any medical or health discipline, except as optional services by some HMOs.

Secondly, there are twice as many optometrists as ophthalmologists. Hence, whatever savings might be achieved by reducing ophthalmologist' office visit fees are more than offset by the number of optometrists who would begin billing for office visits. The HHS report noted, "the assumptions that there would be no increase in utilization of services and no duplication of services...we believe, are probably erroneous."

Access: The proponents of HR 2342 claim that eye/vision care is not accessible. This is based on data at least a decade old. Today, less than one percent of the U.S. population is more than an hour's drive from an ophthalmologist. This is documented in the Academy's ophthalmology manpower study, based on zip code distribution. (see Attachment B). Ophthalmologists are practicing throughout the country, in inner city urban areas, in rural areas, and in alternative settings.

Our senior citizens have convenient access to the comprehensive medical and surgical eye care provided by ophthalmologists. This is supported by HHS, in testimony on similar legislation last year, "we concluded that data did not show that a significant number of beneficiaries are going without eye care services...and, hence, the cost of further extending the coverage of optometrists services does not seem justified. " (Health Care Financing Administration Statement for the Record, on HR 3009 and HR 3010, January 27, 1984).

Difference in Services. Proponents of HR 2342 claim that optometrists services are the same as ophthalmologists. We urge this Committee to consider the significant differences between the two. First, an optometrist, a doctor of optometry, is not a medical doctor. Optometrists are trained in the visual functioning of the eye, and in prescribing and fitting lenses which correct focusing problems, such as near-sightedness and

far-sightedness. Optometrists are well qualified and, we believe, do a good job of prescribing and fitting eyeglasses and contact lenses.

Ophthalmologists are doctors of medicine. We attend medical school, and serve a medical internship and residency, specializing in ophthalmology. We study not only the visual functioning of the eye, but its function as a vital organ of the body, its neurological, vascular and metabolic functions. We study the healthy eye, and the treatment of eye diseases and conditions which cannot be corrected with lenses.

An optometrist attends four years of optometry school, and before being licensed, may be expected to provide routine eye exams for about 300 persons. Only 5% of all optometrists participate in an optometry residency program, for a duration of a year or less. (Journal of the American Optometric Association, 6/85, Vol. 56, No. 6). All practicing ophthalmologists attend four years of medical school, one year of internship, and 3-4 years residency in ophthalmology, during which time they may see a total of 15,000 patients. (see Attachment C).

The differences in services provided by optometrists and ophthalmologists stem from these differences in training. The differences are cognitive: The examination and diagnosis made by

an ophthalmologist is a much more complex cognitive process or services than that provided by an optometrist.

For these reasons, we urge the Committee to reject HR 2342. It is too costly, adding \$100 million or more in the first year. It attempts to equate two different groups of providers, optometrists and ophthalmologists, into one fee structure. It would single out a few providers for mandatory assignment. Its proponents claim it will rectify a problem of access, when there is documentation that there is no problem of access. Indeed, this Committee is grappling with the issue of "oversupply" of physician specialists, such as ophthalmologists, in its consideration of graduate medical education proposals.

National Eye Care Project. The members of the American Academy of Ophthalmology are deeply concerned about the welfare of our senior citizens. To demonstrate this, we are launching this fall, the National Eye Care Project. It is a voluntary, private sector initiative which has been endorsed by President Reagan, HHS Secretary Margaret Heckler and other high-ranking members of the Administration. Its purpose is to alert our senior citizens to the importance of eye care and to provide medical care to those in need. If a patient has no insurance and no means to pay, the care will be free. The Academy did a pilot-test in Michigan, West Virginia and Washington, and learned that we could reach the small minority of patients who need medical eye care, but don't know how or have the means to obtain it. (see Attachment D).

Thank you for this opportunity to express our concerns.



ATTACHMENT A
THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

DEC 6 1982

Report to Congress on Legislative Recommendations on Ootometric Services

Enclosed is a report containing legislative recommendations with respect to the coverage of additional optometrists' services under Medicare, as required by section 937(b) of P.L. 96-499.

Our analysis has not produced compelling arguments or clear data suggesting that the existing legislation must be changed. This view is based on our conclusions that the cost of expanding services is not justified, because we are not convinced that a significant number of Medicare patients are going without needed eye care services because ophthalmologists are not available or accessible to them.

Both the American Optometric Association (AOA) and the American Academy of Ophthalmology (AAO) have furnished us data on the number and location of these practitioners. Considering the data from both sources, it appears that there are more optometrists available to the Medicare population than there are ophthalmologists, but there is no firm data to support a conclusion that Medicare beneficiaries are going without needed covered eye care services. The data submitted by the ophthalmologists show that these specialists are located in all of the 50 States and in an average ratio of 5.0 to 100,000 population. According to several cited studies, this ratio is acceptable. Optometrists are also located in all States and at a higher ratio of 10.4 to 100,000 population. The AOA recommended ratio is 14.3 optometrists to 100,000 population.

Despite the concentration of ophthalmologists in and near the larger urban areas, however, our conclusion from all the data available is that ophthalmologists are accessible to Medicare beneficiaries who reside in suburban and rural areas (considering modern transportation methods) and that the need for visits to ophthalmologists, even for cataract patients, is infrequent.

We have considered the question of whether further coverage of optometrists' services will result in claims for what could be considered duplicate services. For example, an optometrist may discover a cataract during an examination done because the patient complained of impaired vision. At that point, the optometrist would very likely take a history and perform other diagnostic tests. Thereafter, the optometrist would have the patient return periodically so that the optometrist could "monitor" the growth of the cataract. The history, diagnostic tests and monitoring would be covered services. At a later time, the optometrist would refer the patient to an ophthalmologist for surgical removal of the cataract. The ophthalmologist, in order to both institute a case record and to verify the condition, might take a history and repeat some of the tests, in addition to performing additional tests to shed further light on the condition. In situations such as this, where two different types of providers (and of health care practices) are involved, it is difficult to be so prescriptive in regulations that all repetition would be eliminated.

ATTACHMENT A (Continued)

HCFA Estimates of Costs of Coverage of Optometrists' Services (in millions)
Effective 10/1/82

<u>Fiscal Year</u>	<u>Services Related to Cataracts</u>	<u>Other Services</u>	<u>Total</u>
1983	\$20	\$80	\$100
1984	30	100	130
1985	30	120	150
1986	40	130	170
1987	50	140	190

Major Assumptions Used in Cost Estimates

(Source: Actuarial cost estimates prepared by the Office of Financial and Actuarial Analysis.)

1. Services performed by optometrists cost about 10 percent less than those done by ophthalmologists.
2. Those persons who visit an ophthalmologist do so an average of 2.4 times per year.
3. Medicare recognized charges of optometrists and ophthalmologists increase at the same rate as physicians' fees as limited by the increase in the economic index.
4. Average percentage reimbursement under Medicare for new covered services would be the same as it is for currently covered services.
5. Medicare would cover approximately 1/3 of optometrists' initial exams each year if coverage is extended.
6. Optometrists discover approximately 70 percent of cataract cases. The other 30 percent are discovered by ophthalmologists.
7. There is a lag of 3 to 5 years between cataract diagnosis and extraction.
8. Four-fifths of those who are diagnosed as having cataracts by optometrists will continue to be seen by the optometrist. One-fifth will go to an ophthalmologist immediately.
9. Reimbursement for pre-surgical visits to optometrists and ophthalmologists will increase by 1/2 for those who stay with the optometrist.
10. An ophthalmologist will not wish to use the data of the optometrist in his diagnosis. He will perform his own tests, thus duplicating costs.
11. The number of cataract extractions will grow at the same rate as the number of Medicare-reimbursed ophthalmologist visits as projected under present law.
12. One half of an optometrist's pre-surgical patients will return to him for post-surgical care.
13. A patient who returns to his optometrist for post-surgical care will receive two post-surgical exams in that year from his optometrist.

ATTACHMENT B

Ophthalmology Manpower Distribution 1983

Rank	State*	April 1983 Est. Population	Number of Ophthalmol.	Ratio
42	Alabama	3960490	134	3.38
26	Alaska	450540	19	4.22
11.5	Arizona	2906860	168	5.78
29.5	Arkansas	2292650	95	4.14
5	California	25072150	1541	6.15
11.5	Colorado	3167850	183	5.78
4	Connecticut	3096480	195	6.30
38	Delaware	628690	23	3.66
1	DC	604310	91	15.06
6	Florida	10639080	649	6.10
34	Georgia	5696750	226	3.97
13	Hawaii	1003570	54	5.38
46	Idaho	971930	31	3.19
25	Illinois	11457300	800	4.36
18.5	Indiana	5464730	182	3.33
49	Iowa	2902360	90	3.10
40	Kansas	2422850	83	3.43
48	Kentucky	3668980	115	3.13
23	Louisiana	4414140	196	4.44
19	Maine	1135640	53	4.67
8	Maryland	4281170	253	5.91
9	Massachusetts	5795520	342	5.90
31	Michigan	9059830	370	4.08
17	Minnesota	4151480	201	4.84
43	Mississippi	2503900	86	3.36
24	Missouri	4962220	219	4.41
14	Montana	805620	41	5.09

Rank	State*	April 1983 Est. Population	Number of Ophthalmol.	Ratio
33	Nebraska	1591280	64	4.02
39	Nevada	908060	33	3.63
27.5	New Hampshire	960900	40	4.16
15	New Jersey	7462420	376	5.04
29.5	New Mexico	1378470	57	4.14
3	New York	17692660	1119	6.32
36	North Carolina	6066850	233	3.84
41	North Dakota	675610	23	3.40
35	Ohio	10789020	419	3.88
45	Oklahoma	3227160	106	3.28
7	Oregon	2654280	158	5.95
18	Pennsylvania	11864340	561	4.73
10	Rhode Island	961630	56	5.82
50	South Carolina	3230720	98	3.03
47	South Dakota	691330	22	3.18
32	Tennessee	4670800	189	4.05
27.5	Texas	15627160	650	4.16
20	Utah	1584690	72	4.54
2	Vermont	517650	34	6.57
22	Virginia	5538850	247	4.46
16	Washington	4282950	209	4.88
37	West Virginia	1947340	73	3.75
21	Wisconsin	4784800	216	4.51
51	Wyoming	512230	15	2.93
Total		233195890	11210	4.66

* In some cases, state totals include a zip code area that crosses state lines.

Overall, ophthalmologists appear to be quite widely distributed across the United States. Although it has been alleged that a substantial proportion of the population are without the services of ophthalmologists, this appears to be the case for only a few areas. Only 37 of the 532 areas, representing less than 1% (0.8%) of the population, are without convenient access to an ophthalmologist.

The zip code sectional areas have been used as the geographical units to describe the distribution of ophthalmologists.

In many instances, particularly in metropolitan areas, zip code areas are combined to form a multi-coded sectional area whose boundaries reflect the economic and trading patterns of the population.

These same trading factors are often a major consideration in the accessibility of the public to medical providers, and it has been shown that consumer patterns for health care approximate those for goods and services in general.

The hub cities of the areas are usually the natural centers of the local transportation and are, in most cases, within an hour's driving time of the furthest post offices in that area. The exceptions to this are primarily areas in the western United States where some of the areas are larger due to the low population density.

The physician-to-population ratio method has been used frequently to characterize the relative availability of physician services.

Ratio. The ratios presented in the listing are the number of ophthalmologists per 100,000 population.

Number of ophthalmologists. These data were based primarily on the Academy's computerized listing of member and nonmember ophthalmologists.

ATTACHMENT C

A COMPARISON OF
OPHTHALMOLOGISTS AND OPTOMETRISTS

Both ophthalmologists and optometrists provide eye-related services. However, these services are not comparable qualitatively. An ophthalmologist is a doctor of medicine (M.D.) who is trained and licensed to perform comprehensive medical and surgical treatment, while an optometrist (O.D.) is restricted by state licensure generally to the detection of eye conditions and prescription of corrective lenses. The significant differences in training are reflected in the different level of services provided by each. The following is a comparison of the training and licensing in ophthalmology and optometry.

Optometrist
Doctor of Optometry (O.D.)

As an optical professional, an optometrist generally may treat certain visual defects by means of corrective lenses or other methods that do not require license as a medical doctor.

An optometrist's education traditionally consists of two to four years of college, plus four years of optometry school.

Before being licensed, an optometrist will provide routine eye examinations for about 300 persons.

Ophthalmologist
Doctor of Medicine (M.D.)

In addition to examining and treating visual defects by prescribing corrective lenses, an ophthalmologist, as a medical doctor, is licensed to practice medicine, perform surgery, and specialize in all aspects of eye and vision care.

An ophthalmologist's education consists of four years of college, plus four years of medical school, plus four or more years in a hospital-based residency program or clinical fellowship diagnosing and treating injuries, diseases, and disorders of the eye . . . all under the supervision of medical doctors.

During medical school, an ophthalmologist will see about 5,000 patients. During residency, an ophthalmologist will see an additional 9,000 persons suffering from eye injuries and disease.

Source: Iowa Academy of Ophthalmology

ATTACHMENT D



NATIONAL EYE CARE PROJECT™

The Foundation of the American Academy of Ophthalmology

PURPOSE: To provide medical eye care to the disadvantaged elderly through a program of:

- Public awareness
- Medical information
- Quality eye care

PARTICIPANTS: Ophthalmologists of the United States and the nation's needy elderly.

FUNDING: A public-private sector initiative involving members of the American Academy of Ophthalmology, with private sector and foundation contributions and encouragement from the White House and other agencies.

AREA OF OPERATION: Nationwide. Project to be initiated in 12 segments according to population density and geographic location.

METHOD OF OPERATION:

1. A multimedia information campaign with emphasis on eye diseases of the elderly, including celebrity television public service announcements.
2. National toll-free "Helpline" number.
3. Callers over 65 years of age receive:
 - Medical information about eye diseases
 - Referral to a participating ophthalmologist
4. Medical services are provided for those over age 65:
 - With no ophthalmologist
 - Without insurance or the ability to pay
 - With insurance

METHOD OF REFERRAL: Equitable distribution of insured and uninsured patients through a specifically designed computer system which matches callers to participating ophthalmologists.



SPONSOR: The Foundation of the American Academy of Ophthalmology and the State Ophthalmologic Societies of Michigan, Washington and West Virginia.

ENDORSEMENT: The White House: Presidential Announcement

FUNDING AND IN-KIND SUPPORT:

- Mitre Corporation: System design, computer programming and operation support.
- ACTION: Helpline volunteers and office space.
- Apple Computers, Inc.: Personal computers.
- Atlantic Richfield Foundation: Funding.
- CooperVision: Funding.
- Kaiser Aluminum and Chemical Company: Editing of public service announcements.
- Celebrities: Gene Kelly, James Mason, Cary Grant in public service announcements.

DATES: 10 weeks: April 11-June 17, 1983.

PARTICIPANTS: 443 ophthalmologists and their key office staff in Michigan, Washington and West Virginia.

MEDIA IMPACT: Based on circulation figures, 30,460,000 people were reached by newspaper articles and radio and television interviews.

HELPLINE INQUIRIES:

Total Calls: 4,092

Calls for information: 1,357

Calls for medical referral:

- 2,520 were eligible
- 2,450 had insurance
- 92 had no insurance

MEDICAL FINDINGS:

Patients examined by ophthalmologists: 1,180

Cataracts	59.6%
Macular Degeneration	18.3%
Glaucoma	6.7%
Diabetic Retinopathy	3.1%

- 180 received surgical care.
- 77 were referred to other physicians.
- 23.0 had no eye examination in more than five years.
- 52.3% had eye problems for more than one year.
- 86% had some type of eye disease.

Mr. WAXMAN. We appreciate your testimony.

Mr. Whittaker.

Mr. WHITTAKER. I will defer to my colleague on my right.

Mr. WYDEN. Mr. Chairman, I know that Congresswoman Mikulski put considerable time into this issue. I would like to yield my time to her.

Mr. WAXMAN. Ms. Mikulski, 25 minutes for questions.

Ms. MIKULSKI. Did you say 45?

Mr. WAXMAN. I said 25, but I would not argue with you.

Ms. MIKULSKI. I thank you for including this legislation as we take a look at the Medicare Reconciliation Budget Act.

I believe that as we consider budget issues today, that the cost of H.R. 2342 is consistent with our budget targets. The CBO estimates that in fiscal year 1986, it would cost the Medicare Program \$20 million if a common fee screen is used. If the common fee screen is not used, which I think we would be very flexible in discussing because of some of the issues raised by Dr. Frey, the CBO estimates that the cost would be \$20 million.

The minimal cost is well worth the benefits, providing Medicare-eligible payments benefits. So just coming to ask a few questions.

First of all, for Dr. Ferris. Dr. Ferris, how many patients do you see in your practice who are in their late fifties to early sixties?

Mr. FERRIS. About 30 percent of my practice.

Ms. MIKULSKI. Do they pay for that out of pocket or are they covered by third party insurance?

Mr. FERRIS. Many of them have third party payment coverage.

Ms. MIKULSKI. When those folks move into Medicare eligibility age groups, what happens to them then?

Mr. FERRIS. Once they are into that bracket, then they no longer have the third party coverage that they may have had previously, and we quite often see this in the fact that many of the elderly patients do not make the kind of routine visitations that they should for their eye conditions because of fiscal restraints.

Ms. MIKULSKI. Dr. Frey, did you want to comment on that, what you see in your own practice?

Mr. FREY. In our practice, probably about the same percentage—well, probably higher, I would think, in our practice. We see a lot of children and we see a lot of people over 65 because these are the vulnerable age groups of people who have eye problems. The middle aged usually come in much less frequently, so probably about 40 percent, something like that. Not that far off.

Our patients as far as—they come when they have problems, and they come routinely.

I don't think I have any other comment, really.

Ms. MIKULSKI. Dr. Ferris, what do you think would be the dollar impact on the Medicare problem if all beneficiaries received their eye care from medical doctors?

Mr. FERRIS. I don't think I am equipped to answer exactly what that impact would be other than to state that we know that there is a trend for the Medicare recipient to leave the optometric practice and seek out ophthalmological care. Therefore, if that trend were to continue throughout an item, then obviously that would be a full-covered program for all recipients by ophthalmologists and the cost would, in fact, be higher than if we included optometrists

in the program because the fees of the optometrist generally are between 10 and 25 percent less than the ophthalmologist.

Ms. MIKULSKI. Dr. Frey, do you want to comment on that?

Mr. FREY. Would you repeat the question?

Ms. MIKULSKI. Sure. What do you think would be the dollar impact on the Medicare program if all beneficiaries received all of their eye care from ophthalmologists solely?

Mr. FREY. Our academy really is not promulgating all eye care by ophthalmologists only. What we really are saying is that this group of people over 65 is the group of people in our country most vulnerable to eye problems. We feel that people who have eye problems should not be encouraged by any act of Congress to seek care that is not the best.

The difference between the two groups really gets down to what they did to get there. We feel that as far as costs are concerned to the Medicare patient, we feel that—let me just pass on that.

Ms. MIKULSKI. It is a complicated question. If upon further reflection or going back to reflect with the academy staff you want to submit it for the record, that would be fine.

Mr. Chairman, I think essentially you held an extensive hearing in Baltimore on this a year ago. I think that the testimony that the two doctors have given summarizes our basic positions. I do not have any other questions.

I would like to make one other comment to Dr. Frey. Even though we differ on this legislative proposal, I would like to thank the Academy of Ophthalmologists for their national eye care vision project. I congratulate them on their desire to provide the access, and I compliment them on their voluntary effort and the role that the optometrists are playing in that necessary outreach.

The Government can only do so much. We can only pay for so much, and when we see physicians like yourself doing these voluntary efforts to go out to the community and let people know the kind of public information you both have provided, the outreach you have done, it has been wonderful and we thank you for those voluntary efforts.

Mr. Chairman, I have no other questions.

Mr. WAXMAN. I would like to ask a question.

I have heard the concern expressed that this bill would result in the duplication of services in the case of a patient who is referred from an optometrist to an ophthalmologist because the ophthalmologist would want to repeat the diagnostic tests and evaluation done by the optometrist.

Do you agree with that? Should we try to prevent that from happening?

Mr. FERRIS. I do not think that is a major concern we have to worry about in this bill, Mr. Chairman. It would be no more different than the general practitioner who follows the case that has diabetes and gets to the stage where he decides it is a little bit out of what he wants to do and refers the case on to the diabetic specialist.

Mr. WAXMAN. Do you have a view?

Mr. FREY. When I see a patient that is referred to me by an optometrist and I have to make a decision, I certainly do examine that patient again, particularly if there is a surgical decision.

Again, I hate to get back to that, but we get back to the point that I feel that my 8 years of background in dealing with sick people just gives me a different kind of insight than the person who has primarily seen 300 people in his training and does not see sick people.

So yes, I am going to do those same services again because I feel I owe it to that patient.

Mr. WAXMAN. The bill under discussion would authorize payment under Medicare only if the services were covered now by Medicare and if the optometrist is authorized to furnish it. The Medicare Program has relied on the State laws to determine what people are competent to provide what services and to assure that quality standards are met.

Is it your view that such reliance is misplaced in this instance?

Mr. FREY. This is my question. We are dealing with two separate issues. We are dealing with Federal legislation dealing with the Medicare Program that deals with people who are sick. We are not dealing with State programs, Medicaid programs, screening programs.

Dr. Ferris mentioned the Medicaid eye problems dealing with optometrists. Of course Medicaid programs provide all kinds of services that Medicare does not provide and was not set up to provide. Medicare does not provide screening programs. We are dealing with two different issues.

Mr. WAXMAN. Mr. Whittaker.

Mr. WHITTAKER. Mr. Chairman, I really don't have any questions. I just might make a statement. I believe that some of the figures that were quoted with a higher dollar value for the impact of the program were dated 2½ years ago when the original intent of the legislation, one, did not include the fee screen, and second, it included expanded services to a considerable degree, including refractions.

The cost now by some studies is zero neutral, and by CBO it is \$10 million. They can be off \$10 million either way, as we well know. More than likely, it is on the high side. I just wanted to enter that into the record. That maybe was a higher number. That is not the vehicle we are working with today.

Mr. WAXMAN. CBO has given us an estimate, and when we deal with these budgetary matters, we are usually bound by what they estimate, and it is \$20, \$60, and \$75 million for the next 3 years as a cost for this program.

Anything further? If not, then thank you gentleman for your testimony.

Mr. FERRIS. Thank you, Mr. Chairman.

Mr. FREY. Thank you.

Mr. WAXMAN. Our last panel—

Mr. WHITTAKER. I would like to make a minor comment. I think that it might be of somewhat interest to the subcommittee chairman. It has come to my awareness that we have heard differing views on the accessibility of providers to elderly patients, and I reviewed some of the available material from the State of California and thought that might be of interest, using the ZIP Code method—

Mr. WAXMAN. I am a national figure.

Mr. WHITTAKER. This is just purely California. Using the ZIP Code method employed by the ophthalmology study, California breaks down as follows: Of the 58 counties in the State, only 42 have ophthalmologists in practice, while 55 have optometrists. I think this indicates that there is indeed an accessibility problem, and I wanted to bring these cogent figures to the subcommittee chairman's attention.

Mr. WAXMAN. The gentleman realizes the correlation of the ZIP Codes with Democrat versus Republican representatives in the Congress——

That is very high. Thank you for those comments, for whatever value they may have.

Mr. WHITTAKER. One minor point. The cost figures you quoted were without the fee screen, were they not?

Mr. WAXMAN. That's correct.

Mr. WHITTAKER. I would like that recognized in the record.

Mr. WAXMAN. That is a good point to make.

Our last panel. We call forward Sherry Park, vice president, American Clinical Lab Association; Mark Birenbaum, associate administrator, American Association of Bioanalysts; and Sanford Linden, president, National Association of Medical Equipment Suppliers.

We have your statements in the record, and then 5 minutes.

Ms. PARK. Forget the southern accent and talk fast.

Mr. WAXMAN. That is an oxymoron, isn't it?

STATEMENTS OF SHERRY M. PARK, VICE PRESIDENT, AMERICAN CLINICAL LABORATORY ASSOCIATION, ACCOMPANIED BY HOPE FOSTER, COUNSELOR; MARK BIRENBAUM, PH.D., ASSOCIATE ADMINISTRATOR, AMERICAN ASSOCIATION OF BIOANALYSTS; AND SANFORD J. LINDEN, PRESIDENT, NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

Ms. PARK. I am vice president of the American Clinical Laboratory Association, ACLA, an organization of federally regulated independent laboratories. I am accompanied by Hope Foster, ACLA counselor.

I would like to thank the subcommittee for inviting me to testify today.

We have a written statement that we request be included in the record.

I cannot overstate ACLA's opposition to the proposed freeze. First, laboratories have already sustained an overall reduction of 40 percent of the amounts that they had previously received from Medicare testing services. Second, when Congress approved these reductions in laboratory payments, it promised an annual update of the fee schedules to help laboratories meet increasing costs.

Moreover, Congress mandated as a quid pro quo for the reimbursement reductions that HCFA simplify the billing mechanisms that currently overburden and overtax both the program and laboratories. Despite this directive, HCFA has not adopted any simplification measures, and as a result, it would be unfair and a breach of faith to deny laboratories the promised update.

We also understand that members of the subcommittee are considering measures that would clamp ceilings on fee schedule reimbursement. Ceilings which would standardize varying fee schedule amounts would reduce high fee schedule rates but would not affect low fee schedules.

ACLA opposes the reimbursement methodology. Further reductions to reimbursement levels would compound the difficulties laboratories are currently experiencing in adjusting to the already lowered payment level. Second, the current fee schedule methodology recognizes the effect of competitive pricing and the fact that the cost of doing business varies throughout the company. To arbitrarily cap the fee schedule levels by reference to a median or other artificial limit could injure laboratories located in high cost areas, particularly if the methods used to arrive at this ceiling do not consider the frequency with which each test is performed.

Moreover, the proposal would not provide relief to laboratories subject to low fee schedules. Third, the report of discrepancies in the fee schedule limits are not unprecedented. The prevailing charges from which the fee schedules were calculated also varied widely. These prevailings reflected market price realities.

ACLA has seen no evidence to suggest these variations are unreasonable. Despite ACLA's opposition to the proposed freeze and fee schedule ceilings, we are sensitive to the need to cut the Federal deficit. ACLA offers five alternative measures to reduce Medicare outlays for laboratory testing services.

Congress should reduce the fee schedules applicable to hospital outpatient testing from 62 to 60 percent of prevailing charges. Second, Congress should eliminate the DRA provisions that would end fee schedule reimbursement for hospital outpatient testing on July 1, 1987. In addition, current Medicare policy contains loopholes that create incentives for physicians to engage in arrangements that lead to overutilization of testing.

Thus, our third proposal is that laboratory testing that is performed or supervised by physicians should be subject to the same mandatory assignment requirements that now apply to hospital and independent laboratories. Hand in hand with the loophole created by the absence of mandatory assignment in the puzzling fact that Medicare does not require that physicians' office laboratories comply with any quality assurance regulation.

Accordingly, the office laboratories may perform at substandard levels, causing disease to continue undetected and the cost of treatment to escalate when diagnosis finally occurs, and therefore Congress should enact legislation that would require such office laboratories to comply with quality assurance standards.

Finally, physicians who do not want to establish laboratories in their own offices but which do profit from laboratory testing have been investing in laboratories. These arrangements induce physicians to overutilize testing as the more they use the laboratory, the greater the profit distributed to them. Thus, Congress should instruct Medicare to disallow reimbursement to any laboratory for testing sent there by a physician investor.

ACLA believes that if these recommendations are adopted, Medicare will experience substantial savings without the necessity of a fee schedule freeze or ceiling.

We have two additional proposals. First, Congress should direct HFCA to pay laboratories a supplemental fee to cover the costs that laboratories incur in traveling to nursing home and home-bound patients for specimen collection and pickup. Second, Congress should direct HCFA to rescind its May 31 RFP for laboratory competitive bidding demonstration under the RFP when independent laboratories would be excluded from Medicare.

ACLA believes that the demonstration is ill advised for the following reasons. First, when Congress enacted the fee schedule reimbursement methodology, it rejected the administration's fiscal year 1984 budget proposal that the Secretary be authorized to enter into exclusive arrangements or utilize volume purchasing or competitive bidding mechanisms.

Mr. WAXMAN. You get to finish the sentence.

Ms. PARK. Again, let me thank you for the opportunity to participate in this hearing.

[Testimony resumes on p. 613.]

[The prepared statement of Ms. Park follows:]

TESTIMONY OF THE
AMERICAN CLINICAL LABORATORY ASSOCIATION

On the Laboratory Payment Proposals

My name is Sherry Park. I am Vice President of the American Clinical Laboratory Association ("ACLA"), a trade association of federally regulated independent laboratories. All of ACLA's members are certified pursuant to the Medicare Conditions for Coverage of Services of Independent Laboratories and therefore have extensive experience in providing services to Medicare beneficiaries. Before I begin my substantive remarks, I want to thank the Committee for inviting me to testify on a variety of laboratory-related proposals.

This statement provides ACLA's views on: 1) changes to the fee schedule reimbursement methodology (pp. 2-17); 2) extension of the mandatory assignment provisions that are now applicable to independent and hospital laboratories to cover testing performed or supervised by physicians as well (pp. 17-19); 3) adoption of quality assurance standards to apply to physicians' office testing (pp. 19-20); 4) disallowance of Medicare reimbursement to laboratories for tests referred by physician owners (pp. 20-21); 5) adoption of a requirement that the Health Care Financing Administration ("HCFA") reimburse for the expenses that laboratories incur in travelling to nursing home or home bound patients to collect diagnostic specimens (pp. 22-24); and 6) HCFA's plan to experiment with competitive bidding as a procurement mechanism for Medicare laboratory services (pp.

24-29). In addition, at Section II, pp. 15-21, ACLA offers a variety of budget savings proposals.

I. CHANGES TO FEE SCHEDULE REIMBURSEMENT METHODOLOGY

1. Proposed Fee Freeze

The Administration has proposed freezing the Medicare laboratory fee schedule at the rates in effect on June 30, 1985. I cannot overstate ACLA's opposition to this proposal. Laboratories have already sustained an overall reduction of 40% of the amounts they previously received from the Medicare Program in payment for testing services provided to ambulatory Medicare beneficiaries as a result of enactment of the Deficit Reduction Act of 1984 ("DRA"). Thus, just one year ago, pursuant to Section 2303 of that statute, HCFA established fee schedules set at 60% (or in the case of hospital outpatient testing, 62%) of the Program's prior maximum payment levels ("prevailing charges").

Although the President did not sign the DRA into law until July 18, 1984, HCFA retroactively implemented the fee schedule reimbursement methodology, along with its reduced reimbursement rates, and applied them to all clinical testing services provided to ambulatory beneficiaries on or after July 1, 1984. As a result, HCFA instructed carriers, the Medicare contractors charged with the responsibility of determining reimbursement levels and making payments, to withhold payment to laboratories until fee schedule levels had been calculated. Thus, the decision to implement the fee schedule reimbursement

methodology retroactively caused considerable disruption to the industry as laboratories did not receive Medicare payments for a number of months thereafter. In addition, laboratories are still adjusting to the reduced payment rates.

Congress was not insensitive to the problems that laboratories might experience as a result of the reduction in reimbursement levels. Recognizing the severity of this reimbursement reduction and the fact that so long as there is any inflation laboratories will experience increasing costs, the DRA promised an annual adjustment in these reduced reimbursement rates to reflect the changes in the Consumer Price Index.^{1/} Now, only one year later, the Administration proposes that this annual update should be repealed, at least for the period beginning July 1, 1985 and ending either on June 30, 1986 or September 30, 1986. To repeal this adjustment for that period, after so significantly reducing reimbursement levels less than one year ago, is to ask laboratories to bear an unfairly heavy burden in this nation's deficit reduction efforts. While we recognize the urgency of reducing the deficit and indeed actively supported enactment of the DRA as our industry's contribution to reducing

^{1/} The DRA provision states in relevant part that:
 [T]he Secretary shall set the fee schedules...for the 12-month period beginning July 1, 1984, adjusted annually by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average)...
 Section 2303(d), amending Section 1833(a)(2) of the Social Security Act.

that deficit, we feel that the contribution we have already made is sufficient.

In supporting the 1984 DRA, ACLA was cognizant that laboratories would sustain reduced per test Medicare payments. However, ACLA recognized that the laboratory payment provisions contained in the Act promised certain benefits to laboratories that would, if implemented, blunt some of the sting of the reimbursement reductions. Thus, the Act directed HCFA to simplify the Medicare billing, payment and collection process in an effort to reduce the costs incurred by both laboratories and the Program that are associated with these functions. HCFA had previously conceded that unnecessary costs attend these functions. In a report issued by an intra-agency HCFA laboratory task force on February 15, 1984,^{2/} the task force acknowledged that HCFA's billing, collection and payment procedures could and should be simplified, stating:

The Task Force believes that the final step needed to assure program and beneficiary savings is extensive effort to simplify claims processing requirements, particularly for independent laboratories. Among the changes proposed by the Task Force are:

^{2/} This task force report formed the basis for the DRA laboratory payment provisions. Indeed, the task force's recommendations were essentially incorporated in toto in the Act. The task force began studying the industry and the relationship between the industry and Medicare in October 1982. Thus, its report and the recommendations contained therein are the culmination of 17 months of study, investigation, on-site visits and thought. It is the best exposition of the laboratory industry that ACLA has seen.

- (1) deletion of the requirement for a diagnosis on independent laboratory claims, as long as the name of the referring physician is included on the bill;
- (2) requiring carriers to accept and process periodic billings for all of a laboratory's Medicare patients rather than requiring individual claims for each patient;
- (3) limiting the patient-specific information required to the minimum that will permit identification of the beneficiary;
- (4) instituting prompt payment practices; and
- (5) requiring carriers to provide, along with the explanation of Medicare benefit, the laboratory's invoice or specimen accession number to facilitate its reconciliation of Medicare payments with Medicare billings.

Report of Laboratory Task Force, p. 25.

The laboratory payment provisions of the Deficit Reduction Act incorporated these recommendations by requiring:

The Secretary [to] simplify the procedures ... with respect to claims and payments for clinical laboratory tests so as to reduce unnecessary paperwork while assuring that sufficient

information is supplied to identify instances of fraud and abuse.3/

Section 2303(h).

The Conference Committee Report added that this "provision does not require patient diagnosis to appear on bills." Deficit Reduction Act of 1984, Cong. Rpt.'98-861, 98th Cong., 2d Sess., p. 1308.

ACLA viewed these directives as the quid pro quo for not opposing the DRA because of its call for reduced reimbursement levels. However, although ACLA has been working with HCFA since last July in an effort to obtain the mandated simplification, nothing has yet happened. None of the task force's simplification recommendations have been implemented, and a number of carriers continue to require laboratories to supply

3/ The Task Force recognized the importance of detection of fraud and abuse and made the following observation: "While the Program necessarily has to concern itself with identifying and eliminating instances of fraud and abuse and protecting the overall fiscal integrity of the Program, the Task Force believes that instances of fraud and abuse should be viewed as the exception rather than the rule. Billing simplifications need not undermine the Program's ability to eliminate questionable practices. Rather they might well eliminate some of the underlying reasons for such practices by reducing suppliers' costs of doing business with the Medicare Program. Additionally, they represent a good faith effort to rationalize Program payment in a manner that is to all parties' advantage. From this perspective, it may be useful to handle audit and program validation efforts by periodic sampling and linking of laboratory and physician claims processing procedures to try to identify every questionable claim for diagnostic testing." Report of Laboratory Task Force, p. 26.

diagnosis information.^{4/} Thus, ACLA's hopes have gone unrealized that the reduced reimbursement levels would be coupled with claims processing simplifications that would reduce both laboratory and programmatic administrative costs. Moreover, in addition to failing to simplify billing and collection procedures, HCFA has also failed even to propose regulations implementing the discretionary authority provided to the Secretary by the DRA. To eliminate the promised annual update of the fee schedule in the face of the unfulfilled promise of billing simplifications and the failure to promulgate implementing regulations is to tax laboratories with still more reimbursement cuts (the freeze in reality amounts to a reimbursement reduction of 4.1%, the CPI July 1, 1985 update) without any of the offsetting benefits that the DRA was supposed to guarantee. Stated simply, laboratories are being squeezed and the pinch is too tight.

The squeeze that independent laboratories are being asked to sustain is even more crippling because independent laboratory charges have not increased as quickly as the laboratory charges of other members of the health care industry. Indeed, the charges of independent laboratories, when compared with other laboratory providers, have escalated at a

^{4/} ACLA does not challenge HCFA's good faith. HCFA officials have met frequently with ACLA representatives to achieve simplification. However, despite good intentions, the system continues to be unnecessarily cumbersome, burdensome and expensive.

lower rate. Thus, the task force report revealed the following statistics:

Diagnostic Laboratory Charges To Medicare

<u>Specialty</u>	<u>Average Annual Compound Growth Rate 1976-80</u> .
Internal Medicine	7.6%
Independent Labs	6.3%
General Practice	6.7%
Clinic	7.0%
Cardiovascular	15.3%
Family Practice	6.4%
All Others	12.8%

Report of Laboratory Task Force, p. 20.

As these statistics demonstrate, the price to Medicare of independent laboratory services, in general, escalated considerably less sharply during the 1976-80 period than did the amounts Medicare paid others for testing services. Of the specialties seeking payment from Medicare for laboratory testing services, independent laboratories escalated the least, rising a mere 6.3%, well below the health care inflation rate for the period. Because Medicare payments to independent laboratories have remained relatively constant, they are likely to have difficulty incorporating a fee freeze.

Even without the proposed freeze, ACLA members report that they are receiving substantially less per test from Medicare for services than they did before the 40% reduction, as the following chart of the most commonly ordered tests reveals:

Largest Reduction Experienced
By ACLA Members

<u>Test</u>	<u>Reduction</u>
CBC	\$5.80
Platelet Count	\$5.85
Sodium	\$5.90
Potassium	\$6.52
Glucose	\$11.19
Cholesterol	\$11.00
T-4	\$8.75
Urinalysis	\$2.50
Digoxin	\$19.50
Prothrombin Time	\$4.80
SMA-12	\$9.75
SMAC	\$12.33
SMAC-20	\$13.65
Tryglycerides	\$9.70
Electrolytes	\$10.00
Serum Iron	\$9.00
VDRL/RPR	\$7.13
BUN	\$3.95
Calcium	\$7.25
Uric Acid	\$3.55

These reductions were calculated by taking each laboratory's payments from Medicare during May and June of 1984 (before imposition of the fee schedule), adding the 20% that laboratories had received from co-insurance payments and subtracting from that figure current fee schedule amounts. To ask laboratories to forego the 4.1% is to increase the impact of these already substantial reductions.^{5/}

^{5/} That these reductions are substantial is confirmed when one recognizes that the levels of payment that are authorized by the fee schedules are small dollar amounts. For example, one of the fee schedules pays \$7.20 for a CBC. Thus, a reduction from \$13.00 to a reimbursement rate of \$7.20 is significant.

In summary, ACLA opposes the proposed freeze on the Medicare laboratory fee schedule for five reasons:

First, laboratories have already sustained an overall reduction of 40% of the amounts that they previously received in payment for testing services provided to ambulatory Medicare beneficiaries as a result of enactment of Section 2303 of the DRA. Thus, laboratories have suffered large, actual reductions in Medicare payments, as opposed to cuts in the amount of increase in reimbursement levels sustained by other providers of health care.

Second, when Congress approved these reductions in laboratory payments, it promised an annual update of the fee schedules to help laboratories meet increasing costs. Laboratories have made business plans and investments in reliance on this update. Because of the substantial per test reductions that laboratories have already incurred, it would be unfair to deny laboratories the promised update.

Third, Congress mandated, as a quid pro quo for the DRA required reimbursement reductions, that the Health Care Financing Administration simplify the billing mechanisms that currently overburden and overtax both the Program and laboratories. Despite this directive, to date HCFA has failed to adopt any simplification measures. To eliminate the promised fee schedule update in the face of the unfulfilled promise of billing simplification would tax laboratories with even deeper reimbursement cuts without any of the offsetting benefits that

the DRA was supposed to guarantee. Moreover, it would be a breach of faith for Congress to freeze the laboratory fee schedules in the face of HCFA's failure to act and the statutory guarantee of an annual update of the fee schedule amount to reflect the percentage of increase (or decrease) in the Consumer Price Index.

Fourth, independent laboratory charges have not increased as steeply as the charges of other members of the health care industry. Thus, the proposed freeze will work an especially great hardship on independent laboratories, which represent one of the most competitive segments of the health care industry.

Finally, the effects of the proposed laboratory fee freeze, in light of the recent substantial reimbursement reductions that laboratories have experienced, are obvious. The proposal threatens the ability of laboratories to continue providing high quality services to Medicare beneficiaries. These results are so apparent that there is no need to dwell on them.

2. Proposed Fee Schedule Ceilings

ACLA understands that members of this Subcommittee are considering measures that would clamp ceilings on fee schedule reimbursement but that would retain this year's DRA-promised 4.1% increase. We further understand that the goal of these proposals is to standardize fee schedule amounts which reportedly vary widely across the country. This standardization would apparently result in a reduction of high fee schedule rates but would not

affect low fee schedule limits. While ACLA is gratified that members of this Subcommittee are seeking ways to retain this year's CPI update, we oppose any change to the DRA fee schedule reimbursement methodology, particularly if such change were to result in reduced reimbursement for some tests but not increases in such reimbursement for others.

First, as noted above, laboratories have already sustained a substantial reduction in the amounts that they formerly received for Medicare testing services. Further reductions would exacerbate the difficulties that laboratories are currently experiencing in adjusting to lowered payment levels, particularly because HCFA has failed to simplify its billing and collection procedures.

Second, the fee schedule methodology was designed to lower reimbursement based upon the charge data Medicare utilized in calculating reasonable charge payments prior to enactment of the DRA. This methodology made sense as it recognized the effect of competitive pricing and the fact that the costs of providing testing services, which may vary from area to area, were built into laboratory pricing policies and thereby were reflected in the fee schedule limits. To cap arbitrarily the fee schedule levels by reference to a "median" or other artificial limit would fundamentally alter Medicare's Part B laboratory reimbursement philosophy (which has always been based on laboratory charges) and could injure laboratories located in high cost areas, particularly if the methods used to arrive at the ceiling do not

consider the frequency with which each specific test is performed. Moreover, the proposal would not provide relief to laboratories subject to comparatively low fee schedules.^{6/}

Third, the reported discrepancies in the fee schedule limits are not unprecedented. As the fee schedules were calculated from prevailing charges, it is apparent that the prevailings in effect on June 30, 1984 also varied widely. These prevailings reflected marketplace realities, and no one ever commented on the variations. The only difference now is that fee schedule amounts are more visible than prevailing charges were. Nonetheless, ACLA has seen no evidence to suggest that these variations are unreasonable per se or that they justify amendment of the laboratory payment provisions of the DRA.

Fourth, HCFA already has authority to develop regional fee schedules, pursuant to the DRA. Section 1833 (h)(1)(3) of

^{6/} For example, the fee schedule utilized in Maryland is reported to be significantly lower than the fee schedules used in the surrounding states. There is reason to believe that when the Maryland carrier calculated the fee schedule, it failed to include hospital non-patient charge data, as it was required to do, thereby skewing its computations and resulting in lower rates than would have been obtained had the carrier complied with the mandated formula for determining fee schedule levels. Similarly, Michigan, a de facto direct-billing state, and New York, an actual direct-billing state, have lower than average fee schedules, despite the directive in the DRA conference report that: "The conferees intend that in those States that already require direct billing for laboratory services the Secretary will take into account the fee levels in surrounding States when establishing the fee levels in direct billing States." Deficit Reduction Act of 1984, 98th Cong., 2d Sess., Rpt 98-861, p. 1306. HCFA officials have conceded that they did not direct carriers to comply with this instruction.

the Social Security Act directs that the fee schedules "be established on a regional, statewide or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished during the period beginning on July 1, 1984 and ending on June 30, 1987." This provision obviates the need for any additional statutory revisions. Thus, if HCFA feels that the fee schedules need to be adjusted, it can go to regional, rather than carrier-wide, schedules. However, if such a change is to occur, the frequency with which each test is conducted must be considered and the calculations should be conducted using HCFA's formula for determining prevailing charges. Frequency must be considered to assure that the fee schedules will be set at fair and adequate levels.

Finally, when Congress enacted the fee schedule provisions, it envisioned a three-year transition to a nationwide fee schedule.^{7/} Only the first year of that transition has elapsed, and yet proposals are being discussed to reduce further fee schedule reimbursement. Given the fact that HCFA has not yet proposed implementing regulations or corrected its expensive billing and collection procedures, such proposals are grossly unfair. If increased Medicare savings are necessary, they should

^{7/} The adoption of a ceiling on fee schedule reimbursement could affect calculations of the nationwide fee schedule. Naturally ACLA is concerned about any proposal that might affect the nationwide fee schedule in a fashion that is not understood by the laboratory industry.

be obtained by implementing the proposals discussed at Section II of this Statement.

II. ACLA BUDGET SAVINGS PROPOSALS

Despite ACLA's opposition to the proposed freeze and fee schedule ceilings, we are sensitive to the need to cut the federal deficit. Thus, ACLA offers five alternative measures that, if implemented, would reduce Medicare outlays for laboratory testing services. These proposals relate to the amounts that Medicare pays for testing services as well as incentives that currently exist for physicians to order more tests than may be appropriate or medically necessary.

First, ACLA recommends that Congress reduce the fee schedules applicable to hospital outpatient testing from 62% of prevailing charges to 60% of prevailing charges.^{8/} Such a reduction would set hospital outpatient testing reimbursement at the same level as services provided by independent and physicians' office laboratories as well as by hospital laboratories to non-

^{8/} The original House bill that the Energy and Commerce Committee approved and that led to the DRA called for a fee schedule set at 60% for all laboratory testing services provided to ambulatory Medicare beneficiaries. The Senate Finance Committee proposed the 62% fee schedule for hospital outpatient testing.

patients.^{9/} ACLA has never understood the need for a higher fee schedule for hospital outpatient testing and believes that substantial reductions in Medicare outlays could be achieved by making hospital outpatient testing reimbursable pursuant to the same 60% fee schedule as applies to independent, physician office, and hospital non-patient laboratory testing.

In addition to these savings, the proposal is sound policy as it would result in site-neutral reimbursement, a concept endorsed by the Administration and long sought by ACLA. The principle underlying site-neutral reimbursement is that the same payment rules should apply to all providers and suppliers of the same service. To pay hospital outpatient testing at a higher fee schedule than applies to other laboratory testing services is to provide incentives for the provision of increased services by hospital outpatient departments. Medicare reimbursement policy should not provide any incentives that favor one segment of the market over another. Thus, in addition to achieving savings, this proposal would place all laboratory competitors on an equal footing.

For the same reasons, ACLA offers its second proposal -- elimination of those provisions of the DRA that would end the

^{9/} "Non-patients" are typically patients of physicians who choose to send specimens to a hospital for testing. In this situation the hospital laboratory acts like an independent laboratory. A "hospital outpatient" is one for whom the hospital maintains a hospital record and for whom hospital employees provide a service. Typically, a hospital outpatient goes to the facility for specimen collection and has some pre-existing relationship with the hospital.

fee schedule reimbursement methodology for hospital outpatient clinical laboratory testing services on July 1, 1987. We strongly favor repeal of this sunset provision contained in Section 2303(d) of the Act. During consideration of the DRA, ACLA opposed the sunset provisions, as we, like the Administration, have consistently favored adoption of uniform laws, regulations and rules applicable to all laboratories, regardless of the laboratory's site. Thus, we see no reason for treating hospital outpatient testing differently from testing services provided to Medicare ambulatory patients by independent or physicians' office laboratories. Moreover, adoption of this proposal is likely to yield additional savings. Finally, it makes no sense to require Congress to reauthorize application of the fee schedule reimbursement methodology to hospital outpatient testing in 1987.

In addition, current Medicare laboratory policy creates incentives for physicians to engage in arrangements that lead to overutilization of testing services.^{10/} Thus, ACLA's third

^{10/} That physicians tend to overutilize is confirmed by a recent report of the Office of Inspector General on "Using the Computer Against Fraud and Abuse in Medicare and Medicaid" (May 1985). In reviewing comments of 1300 respondents to a survey of federal, state and private organizations, the report identified major program vulnerabilities and observed that "of the numerous combinations among health care providers and vulnerability categories, the one most frequently referenced was excessive services furnished by medical practitioners and hospitals. Within this grouping of health providers, the survey respondents identified inpatient hospitals and physicians most frequently susceptible to this type of abuse ..." pp. 4-5.

proposal is that laboratory testing which is performed or supervised by physicians should be subject to the same mandatory assignment requirements that now apply to hospital and independent laboratories, as a result of the DRA.

Currently, hospital and independent laboratories must accept assignment of Medicare patients' rights to reimbursement and must directly bill the Program for those payments. In establishing these requirements, however, the DRA exempted laboratory tests performed or supervised by physicians from the mandatory assignment provisions. This exemption has encouraged the formation of additional and more extensive physicians' office laboratories as well as shared service laboratories^{11/} to enable these physicians to continue to profit from laboratory testing because physicians may bill Medicare beneficiaries for services performed in physicians' testing facilities. This loophole allows physicians operating office laboratories to charge uncontrolled prices for laboratory tests with beneficiaries only

^{11/} A shared service laboratory is a laboratory established by physicians who do not share a practice but who combine to form a laboratory to perform testing for the patients of the physician owners. HCFA has suggested that it may plug this loophole once it promulgates regulations implementing the discretionary portions of the DRA laboratory payments provisions; however, as noted above, these regulations have not even been proposed.

receiving from the Program 80% of the fee schedule price.^{12/} Moreover, because the absence of mandatory assignment requirements applicable to physician's office testing has led to the proliferation of office laboratories, increased utilization of testing by those physician lab operators is likely to occur. There is little doubt that physician involvement in testing tends to increase utilization because of the financial benefits that result from such testing.^{13/} Needless to say, when increased ordering occurs, Medicare outlays escalate.

Hand-in-hand with the loophole created by the absence of mandatory assignment is the puzzling fact that Medicare does not require that physicians' office laboratories comply with any of the quality assurance regulations applicable to other laboratories. Thus, Medicare exempts physicians' office laboratories from these standards. As a result, the expense that attends compliance with these regulations does not apply to physicians' office laboratories, and few barriers to entry exist for physicians wishing to continue earning profits from laboratory testing services. In addition, because of the absence of any quality assurance regulation, these physicians' office laboratories may

^{12/} While this scenario does not result in increased outlays for the Program, it does injure beneficiaries. Thus, if a doctor charges a beneficiary \$20.00 for a test that is listed on the fee schedule at \$10.00, the beneficiary will only receive \$8.00 from the Program and will owe the doctor \$12.00.

^{13/} Physicians are in a unique position when they perform testing services as they control both demand and supply. The incentives to overutilize are obvious.

perform at substandard levels creating the potential that disease will continue undetected. When illness remains undiagnosed, the costs of treatment, when diagnosis finally occurs, are usually higher than they would have been had the condition been diagnosed earlier.

Thus, ACLA's fourth recommendation is that the United States Congress enact legislation that would require physicians' office laboratories to be certified by the Medicare Program under the same regulations that apply to independent laboratories. Such a measure would assure that Medicare is receiving value for the monies it spends on testing performed in physicians' offices. Enactment of such a proposal would also discourage physicians from starting laboratories if the principal reasons underlying the decision to perform laboratory tests are financial rather than medical.

Finally, ACLA has observed that physicians who do not want to establish laboratories in their own offices but who do wish to profit from laboratory testing have been investing in laboratories (often called "captive laboratories") to receive profit distributions.^{14/} In general, these arrangements work as follows. An entrepreneur decides to offer physicians who refer laboratory testing the opportunity to invest in a laboratory. Many physicians are accepting such offers. Then the physician

^{14/} ACLA is prepared to share with the Subcommittee specific information about how these arrangements work and how they are being marketed.

investors refer their testing to the captive laboratory. The captive laboratory in turn distributes profits to the investing physicians. These arrangements cannot help but induce physicians to overutilize testing services as the more the captive laboratory is used the greater the profit to be distributed to the physician investors. A recent May 9, 1984 report issued by Michigan Blue Cross and Blue Shield (a copy of which is attached hereto) confirms that physician investment in captive laboratories leads to overutilization. It concludes at p. 1 that "[t]he number of services per patient in the physician-owned lab group is ... 20.97% higher than the average for all labs and ... 39.65% higher than the average for non-physician owned labs." Thus, ACLA's fifth budget savings proposal is that the Medicare Program should disallow reimbursement to any laboratory for testing services performed on specimens sent to that laboratory by a physician-investor.^{15/}

ACLA believes that if all five of these recommendations are adopted, the Medicare Program will experience substantial cost savings without the necessity of a fee schedule freeze or ceiling.

^{15/} ACLA is not the only voice to express concern about these arrangements. Others include the Federal Bureau of Investigation, Arnold Relman, M.D., Editor of the New England Journal of Medicine, the Michigan Medicaid Program, Region V of the Health Care Financing Administration and the States of New York and Michigan.

III. PROPOSAL TO RECOGNIZE TRIP FEES

Under current Medicare reimbursement policy, laboratories that collect diagnostic specimens from patients who come to the facility for the collection service are entitled to receive a \$3.00 specimen collection fee from Medicare. Although ACLA supports this policy, nagging and persistent problems continue in the specimen collection area. Thus, if a laboratory sends phlebotomists to a nursing home or home bound patient, the Program fails to pay for any of the costs associated with the travel. Laboratories should be reimbursed for the services that they provide when they must travel to a nursing home or home bound patient to collect laboratory specimens. These services include both transportation and specimen collection, and separate fees should be recognized for each. The current policy, which only recognizes a specimen collection fee of \$5.00 when one patient is drawn or \$3.00 when multiple patients are drawn, is inadequate. One ACLA member has calculated that the direct costs of performing a venipuncture on a nursing home patient is \$7.50, a figure that includes no overhead allocations. Simply stated, laboratories should be reimbursed more when they employ trained phlebotomists to travel to the patient to collect specimens than these facilities receive when the patient travels to the

laboratory for specimen collection.^{16/} Under the current reimbursement policy, a laboratory only receives an increased payment if it collects from one nursing home or homebound patient. However, if it collects from multiple nursing home patients, no additional payment is recognized. Obviously a laboratory incurs higher costs when it must travel to the patient than when the patient comes to the laboratory. Thus, this Subcommittee should instruct HCFA to remedy this problem.

In addition, HCFA should be directed to recognize a supplemental fee for special, non-routine house calls to pick up specimens.^{17/} Again, a laboratory incurs costs in employing persons to travel to a patient even if that employee does not provide any specific collection service when he arrives at the patient's residence. Failure to recognize the additional costs that a laboratory experiences when it must employ persons to travel to the patient may undercut a laboratory's ability to provide specimen pickup from nursing home and home bound patients.

The provision of care to nursing home and home bound patients is growing rapidly, a phenomenon that has accelerated in

^{16/} Significantly, drawing blood from elderly patients residing in nursing homes is often difficult and time consuming, requiring patient, highly trained phlebotomists. These phlebotomists must often provide services at odd hours of the day and night and be available on call for emergencies.

^{17/} By special, non-routine house calls, we are referring to those pickups that are not part of the laboratory's routine courier service.

response to earlier discharges caused by the DRG-based reimbursement system applicable to hospital inpatient services. Thus, ACLA members are experiencing increased requests for nursing home and homebound collection and pickup services. The provision of these services is substantially less expensive for the Program than transporting the patient by ambulance to a hospital for the provision of the services. Therefore, ACLA strongly urges this Subcommittee to approve legislation that would recognize and pay for the increased costs that laboratories incur when they provide specimen pickup and collection services to nursing home and home bound patients. The easiest way to accomplish this goal would be for the Subcommittee to approve legislation directing that the Secretary pay a reasonable trip fee based on mileage.

IV. OPPOSITION TO HCFA PROPOSAL TO EXPERIMENT WITH COMPETITIVE BIDDING

On May 31, 1985, HCFA issued a request for proposal ("RFP") announcing that it intended to initiate a demonstration pursuant to which Medicare testing services in certain geographic sites would be procured via competitive bidding. According to the RFP, hospital laboratories providing testing to nonpatients and independent laboratories would not be eligible to provide covered services unless selected as bid winners. Thus, bid losing or non-bidding laboratories would be excluded from participating in the Medicare program. The principal criterion for selecting bid winners would be price. Reimbursement for

hospital outpatient testing and physician's office testing, although available, would be no higher than bid-winning prices. ACLA strongly opposes this demonstration and urges this Subcommittee to direct that the RFP be rescinded.

First, as this Subcommittee well knows and as discussed above, last year Congress replaced Medicare's reasonable charge reimbursement methodology for laboratories with fee schedules, slashing per test laboratory reimbursement by an overall 40% and mandating other significant changes that have substantially disrupted the industry. In the face of the recent and as yet incomplete implementation of fee schedule-based reimbursement, use of competitive bidding, even on an experimental basis, is both premature and ill-advised. Any knowledge gained by a demonstration conducted at this time will have little to no predictive value given the recently modified reimbursement environment. Moreover, substantial cuts in laboratory reimbursement have already been achieved, and additional savings are projected for the future.

Second, when Congress enacted the fee schedule reimbursement methodology, it sub silentio rejected the Administration's proposal, contained in its FY 1984 budget package, that the Secretary be authorized to enter into exclusive arrangements or utilize volume purchasing or competitive bidding mechanisms for obtaining testing services for Medicare beneficiaries. This Subcommittee, like the HCFA laboratory task

force,^{18/} discussed above, obviously concluded that competitive bidding was not an appropriate procurement vehicle and chose the fee schedule approach instead. Now, HCFA seeks to ignore the will of Congress, as expressed in the DRA, and through this competitive bidding "demonstration," deprive beneficiaries of their statutorily-guaranteed right to choose their health service suppliers.

Third, Medicare beneficiaries will be adversely affected as competitive bidding will not only strip them of freedom of choice but will also probably compromise the quality of laboratory testing. Previous governmental use of competitive bidding has resulted in poor laboratory testing and has even

^{18/} In its report, the task force opted for fee schedule reimbursement rather than competitive bidding and noted that it had a number of reservations about competitive bidding, including: 1) "the disruptive effect that limiting the number of Medicare-participating laboratories could have on the industry as a whole"; 2) the creation of "local monopolies"; 3) the possibility that it could "result in higher costs to Medicare in the long run as fewer laboratories remained in business"; 4) the potential for deterioration in the quality of testing; 5) the probability that "low-ball" bids would be submitted; 6) the potential inability of the Program to interest back-up laboratories in performing at the bid prices in the event that winning laboratories proved unable to deliver the services; 7) the likelihood that "physicians dissatisfied with the service of a winning laboratory or the quality of its results [might] use non-participating laboratories and thus leave the beneficiary totally at risk for the cost of lab tests"; and 8) the creation of numerous administrative problems. pp. 23-24.

caused several deaths.^{19/} Medicare beneficiaries may also be deprived of testing services should the bid winner experience an equipment or facility breakdown or be otherwise unable to perform. Furthermore, beneficiaries may be deprived of timely laboratory services and convenient, easily accessible locations for specimen collection, a particular hardship for the elderly. Nor will beneficiaries enjoy any offsetting benefits as they currently have no cost-sharing obligations when their clinical testing needs are fulfilled by an independent or hospital laboratory.

Fourth, competitive bidding will impair competition among clinical laboratories, creating long-term injuries to the marketplace. Physicians do not split patronage among several laboratories. Thus, a laboratory bid winner will likely prosper while non-bid winners will lose both Medicare and non-Medicare business, possibly forcing them to sell to bid winners or to go out of business completely. Accordingly, the demonstration will reduce and eliminate competition, resulting in long-term distortion of local market forces -- distortions that will last far beyond the life of the demonstration and that may permanently impair the competitive environment in the region. Moreover, reduction in the number of laboratories available to service Medicare patients may ultimately force the Program to deal with

^{19/} These tragedies are recounted in the task force report at p. 23 and in ACLA statements opposing competitive bidding. ACLA would be pleased to share the information it has on this subject with the Subcommittee.

the few laboratories that remain. Those laboratories may be able to command uncompetitive prices from the Program.

Fifth, the RFP compromises the Administration goal (a goal ACLA shares) of achieving a level playing field on which laboratories compete. Thus, non-winning independent laboratories are excluded from receiving Medicare payments, hospitals may decline to bid and still obtain Medicare reimbursement, and physicians are precluded from bidding but can still provide covered testing services, despite that fact that physicians' office laboratories remain exempt from Medicare's quality assurance standards. This differing treatment discriminates against independent laboratories and represents poor policy.

Sixth, competitive bidding may also cause increased hospitalizations. If a physician cannot obtain prompt specimen collection services or timely test results from a bid-winner, he may opt to hospitalize his patient rather than order the service from the bid-winner.

Seventh, physicians dissatisfied with the bid winner may open their own laboratories or expand the use of their preexisting laboratories. As physicians' office laboratories are exempt from Medicare quality assurance regulation, this response will deprive the Program of any guarantee that the testing is reliable, accurate or precise.

Eighth, the administrative costs of the demonstration will likely be high. These expenses should not be incurred in this era of cost containment, particularly as there can be no

assurance that the demonstration will result in reduced Medicare outlays. ACLA has seen no projections on any savings that might result from such a demonstration.

Congress recently instructed Medicare to reimburse laboratories under new methodologies which promise substantial savings to the Program. In light of these changes and the disadvantages of competitive bidding, ACLA strongly urges that this Subcommittee instruct HCFA to rescind the competitive bidding RFP.

V. CONCLUSION

In summary, ACLA opposes proposals to freeze or cap reimbursement pursuant to the fee schedules, particularly in light of HCFA's failure to simplify its billing and collection procedures or promulgate regulations implementing the discretionary portions of the DRA's laboratory payments provisions. Dealing with the Program is expensive. While per test payments to laboratories have been substantially reduced, the costs of doing business with the Program have not. If additional savings are necessary ACLA proposes: 1) reduction of the hospital outpatient fee schedule to 60%; 2) elimination of the 1987 sunset provision applicable to hospital outpatient testing; 3) extension of mandatory assignment to physicians who perform or supervise laboratory testing; 4) imposition of quality assurance standards on physicians' office laboratories; and 5) disallowance of reimbursement for testing referred to laboratories by physicians who have invested in such laboratories. In addition, this Subcommittee should direct HCFA to pay trip fees to assure that nursing home and home bound patients continue to receive needed laboratory testing service. Finally, this Subcommittee should direct HCFA to rescind its competitive bidding RFP.

Again, let me thank you for the opportunity to participate in this hearing. ACLA would be pleased to supply this Subcommittee with additional information or respond to questions. Thank you.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN
MEDICAL AFFAIRS DIVISION

5/9/64

COMPARISON OF LABORATORY UTILIZATION AND PAYOUT TO OWNERSHIP:I. Background

This study was undertaken to identify the differences, if any, in average payment and average number of laboratory services per identifiable BCBSM patient on the basis of laboratory ownership.

II. Method

The claims data for all laboratory services for 3Q83 were reviewed for all independent laboratories (148) in the state of Michigan. The variables of -- 1) Total Payment; 2) Total Number of Services; 3) Total Number of Patients; 4) Average Payment Per Patient; and, 5) Average Number of Services Per Patient, were identified for each of the 148 laboratories.

From this list, 20 laboratories known to have physicians (other than Pathologists) involved in ownership were selected as a sample and 20 laboratories known not to have physicians (other than Pathologists) involved in ownership were selected as the second sample. These two samples, totalling forty (40) labs, represent approximately two-thirds of the total payout and services rendered by the 148 labs in the state.

Table I lists the twenty (20) physician-owned laboratories showing Average Payout; Average Number of Services; Total Payout; Total Number of Services; and Total Number of Patients, for each individual laboratory.

Table II lists the twenty (20) non-physician-owned laboratories showing the same data elements.

Table III was designed to compare both samples to each other and to the total group.

The average payment per patient in the physician-owned lab group is \$8.26 (22.59%) higher than the average for all labs and \$19.34 (43.15%) higher than the average for the non-physician-owned labs.

The average number of services per patient in the physician-owned lab group is 1.08 (20.97%) higher than the average for all labs and 2.47 (39.65%) higher than the average for the non-physician-owned labs.

COMPARISON OF LABORATORY UTILIZATION AND PAYOUT TO OWNERSHIP (continued)...

The range for each of these data elements for the two groups is compared below:

	<u>R A N G E</u>	
	<u>Aver. Payment Per Patient</u>	<u>Aver. Number Service Per Patient</u>
Physician Owned	\$21.33 - \$123.18	3.42 - 20.72
Non-Physician Owned	\$ 7.15 - \$ 30.33	1.67 - 4.68

III. Summary

Since referring physician could not be directly linked to laboratory work in the past, it is impossible to determine just how much of the laboratory testing in the physician-owned labs was requested directly by physician owners. However, the data does suggest that the overall utilization in a physician-owned laboratory is significantly higher (40%) than that seen in non-physician-owned labs.

	<u>Payment Per Patient</u>	<u>Services Per Patient</u>
Physician-Owned:	\$44.82	6.23
Non-Physician-Owned:	\$25.48	3.76

This study supports similar work undertaken by the Medicare Program Region V in May of 1983 which revealed a 34% higher payment level for patients receiving services from a physician-owned lab than for those receiving services from non-physician-owned labs.

TABLE I

PHYSICIAN OWNED LABORATORIES 3083
(Non-Pathologist)

LAB CODE	Avg. Payout Per Patient	Avg. No. Services Per Patient
01	\$ 34.10	4.82
02	58.02	7.35
03	89.12	9.80
04	52.00	7.65
05	36.21	5.24
06	52.87	7.75
07	87.84	11.82
08	32.09	5.56
09	27.09	4.02
10	58.30	8.28
11	23.91	4.37
12	89.91	11.33
13	21.33	3.84
14	40.35	10.17
15	123.18	9.57
16	53.61	6.17
17	91.10	13.57
18	29.76	4.73
19	118.63	11.27
20	92.07	20.72
AVG.	\$44.82	6.23
TOTAL PAYOUT \$4,962,856		
TOTAL SERVICES 689,339		

TABLE II

NON-PHYSICIAN OWNED LABORATORIES 3083
(Lay person or Pathologist)

LAB CODE	Avg Payout Per Patient	Avg. No. Services Per Patient
01	\$ 27.28	3.76
02	23.42	2.84
03	28.18	4.56
04	24.96	3.94
05	22.76	4.07
06	18.85	3.31
07	30.33	4.53
08	28.25	3.92
09	10.93	3.26
10	21.88	4.20
11	18.31	3.15
12	21.13	2.80
13	12.40	2.18
14	16.85	2.41
15	27.82	4.68
16	7.15	2.18
17	9.87	1.99
18	19.37	2.98
19	31.50	1.67
20	25.96	1.95
AVG.	\$ 25.48	3.76
TOTAL PAYOUT \$3,329,137		
TOTAL SERVICES 691,666		

TABLE III

COMPARISON: PHYSICIAN OWNED TO
NON-PHYSICIAN OWNED TO TOTAL

	Avg. Payment Per Patient	Avg. Services Per Patient	Total Services 3083	Total Payment 3083	Total Services 3083	Total Patients
All Independent Labs in State (N=148)	\$ 36.56	5.15	\$12,082,842	1,700,752	330,507	
Physician Owned Sample of N=20	\$ 44.82	6.23	\$ 4,962,856 41.07%	689,339 40.53%	110,733 33.50%	
Non-Physician Owned Sample of N=20	\$ 25.48	3.76	\$ 3,329,137 27.55%	491,646 28.91%	130,651 39.53%	
Combined Samples N=40			\$ 8,291,993 68.63%	1,180,985 69.44%	241,384 73.03%	

Mr. WAXMAN. Thank you very much for your testimony.
Mr. Birenbaum.

STATEMENT OF MARK S. BIRENBAUM, PH.D.

Mr. BIRENBAUM. Thank you, Mr. Chairman.

I am Dr. Mark Birenbaum, associate administrator of the American Association of Bioanalysts. To my right is Alvin Soltan, president of AAB.

As you recall, the Health Care Financing Administration empaneled the task force several years ago to study reimbursement for laboratory testing services under Medicare and Medicaid. It developed a report which formed the basis of the laboratory fee schedule.

The HCFA Laboratory Task Force report did stress that its recommendations must be adopted as an entire package. If not, it warned that Medicare payment reductions are likely to yield program savings merely at the expense of beneficiaries.

Mr. Chairman, the final version of the laboratory fee schedule as signed by the President did not adopt the task force recommendations as a package, and we fear that the beneficiary is now paying more than before the DRA. Let me explain.

There are basically three players in the system. The independent clinical laboratory, which provides only part B supplier laboratory services, is (a) subject to mandatory assignment, (b) receives 60 percent of the prevailing rate for its testing, (c) must meet stringent Medicare standards for internal and external quality control and requirements for qualified personnel, and (d) will be subject to the national fee schedule by 1987.

The hospital outpatient laboratory (a) receives 62 percent of the prevailing rate for its testing services, (b) would be sunsetted—in other words, exempt from the 1987 national fee schedule, and (c) has much less stringent standards, particularly for personnel.

The physician who provides part B laboratory supply services for his or her patients is (a) not required to take assignment, (b) has no Medicare requirements or standards for his or her laboratory testing procedures, equipment or personnel, and (c) is not subject to the physician fee freeze because laboratory services are part B supplier services and not physician services, and therefore, physician laboratory services are not subject to the physician fee freeze, and the physician can increase his or her charges to the beneficiary for laboratory testing.

Mr. Chairman, the Deficit Reduction Act of 1984 established an uneven playing field for those providing laboratory services. The most stringent requirements under the law are placed upon the independent clinical laboratory, which provides no other services than part B supplier services, whereas the hospital and physician office laboratories, which provide other services, are operating under a different set of rules.

The failure to provide this level playing field has resulted in a dramatic increase in laboratory testing performed in physician offices, resulting in the beneficiary paying more for laboratory services.

Mr. Chairman, under the fee schedule, the 60-percent rate has definitely reduced the amount of reimbursement our members are receiving for their laboratory services. In fact, because of the mandatory assignment provision, which physicians do not have to meet, our members have taken a 40-percent reduction, 20 percent from the loss of the coinsurance and 20 percent from reducing the Medicare allowable rate from 80 percent to 60 percent of the prevailing rate.

Parenthetically, we would like to add that we disagree with Dr. Davis' statement earlier today, because of this 40-percent reduction, that the scheduled increase of 4.1 percent on July 1, 1987 should not be continued.

If the savings that were designed by the Deficit Reduction Act are being realized, they must be coming at the expense of the beneficiary, who is paying more money for laboratory testing done in physician office laboratories. We remind all concerned that the HCFA Laboratory Task Force's sole recommendation with respect to assignment was that "HCFA policy be uniform for both physicians and independent laboratories." The HCFA Task Force warned that if physicians are not required to accept assignment, they would continue to be able to pass on the higher charges to beneficiaries than the Medicare program would recognize, and in addition, the Medicare program realizes savings because the deductible and coinsurance still apply on nonassigned claims.

Therefore, program savings are accruing at the expense of the beneficiary and to the advantage of the physician. We therefore recommend that changes be made which would require mandatory assignment for all providers of part B laboratory supplier services and the same standards for proficiency testing and personnel be applied to all providers of clinical laboratory part B supplier services, and that hospital outpatient laboratory services be included in the national fee schedule effective, July 1, 1987.

Then and only then will the rules be uniform and this fee schedule be most effective, as all of these requirements are interrelated.

I would like to reference two other points. First, several years ago HCFA developed a model for competitive bidding. That proposal would have excluded all laboratories from Medicare reimbursement except the winning bidders. The HCFA Task Force received this recommendation and concluded that there was a better alternative; namely, the laboratory fee schedule that was enacted last year.

The intent behind the laboratory fee schedule legislation was to establish a fee schedule which would make competitive bidding unnecessary.

Thank you, Mr. Chairman.

[Testimony resumes on p. 640.]

[The prepared statement of Mr. Birenbaum with attachments follows:]



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Statement of Mark S. Birenbaum, Ph.D.

Associate Administrator, American Association of Bioanalysts

St. Louis, Missouri

on Recommended Changes to the Laboratory Fee Schedule

Before the Subcommittee on Health

House Committee on Energy and Commerce

July 17, 1985

Thank you Mr. Chairman. We have prepared a formal statement for the record and in the interest of time I would like to summarize our comments but will insert the entire statement into the record.

I am Dr. Mark Birenbaum, Ph.D., Associate Administrator of the American Association of Bioanalysts, an organization made up of over 1,000 members who are directors, managers, supervisors and owners of independent community clinical laboratories across the United States. We appreciate the opportunity to share our comments with you and the Committee on the implementation and impact of the laboratory fee schedule which was enacted last year. As you will recall, the Health Care Financing

*Member, National Commission for Health Certifying Agencies and the
National Council on Health Laboratory Services.*

Administration (HCFA) empanelled a "Task Force" several years ago to study reimbursement for clinical laboratory testing services under Medicare and Medicaid. The Task Force was comprised of eleven experts from the Health Care Financing Administration. They developed a report which formed the basis of the laboratory fee schedule. The HCFA Laboratory Task Force Report stressed that its recommendations must be adopted as an entire package. If not, it warned that "Medicare payment reductions... are likely to yield program savings merely at the expense of beneficiariaries" (p.26). Mr. Chairman, the final version of the laboratory fee schedule as signed by the President did not adopt the Task Force recommendations as a package, with the predicted results, i.e., the beneficiary is now paying more than before the DRA. Let me explain.

There are basically three players in this system. The INDEPENDENT CLINICAL LABORATORY (which provides Part B laboratory supplier services); the HOSPITAL, which provides many services in addition to Part B laboratory services; and the PHYSICIAN, who provides his/her services to patients in addition to Part B laboratory supplier services. Yet Mr. Chairman, as stated, the final version of the law treats these three providers differently.

The INDEPENDENT CLINICAL LABORATORY, which provides only Part B supplier laboratory services, is:

- a) subject to mandatory assignment;

- b) receives 60% of the prevailing rate for its testing;
- c) must meet stringent Medicare standards for internal and external quality control, and requirements for qualified personnel;
- d) will be subject to the national fee schedule by 1987.

The HOSPITAL OUTPATIENT LABORATORY:

- a) receives 62% of the prevailing rate for its testing services;
- b) would be sunsetted i.e., exempt, from the 1987 national fee schedule; and
- c) has much less stringent Medicare standards than independent clinical laboratories for laboratory testing.

The PHYSICIAN who provides Part B laboratory supplier services for his/her patients:

- a) is NOT required to take assignment;
- b) has no Medicare requirements or standards for his/her clinical laboratory testing, procedures,

equipment or personnel;

- c) is not subject to the physician fee freeze because laboratory services are Part B supplier services and not physician services. Therefore physician laboratory services are not subject to the physician fee freeze and the physician can increase his/her charges to the beneficiary for laboratory testing.

Mr. Chairman, the Deficit Reduction Act of 1984 established an uneven playing field for those providing laboratory services. The most stringent requirements under the law are placed upon the independent clinical laboratory which provides no other services, whereas the hospital and physician office laboratories, which provide other services, are operating under a different set of rules. The failure to provide this level playing field has resulted in a dramatic increase in laboratory testing performed in physician offices, resulting in the beneficiary paying more for laboratory services.

Mr. Chairman, under the fee schedule the 60% rate has definitely reduced the amount of reimbursement our members are receiving for their laboratory services. In fact, because of the mandatory assignment provision, which physicians do not have to meet, our members have taken a 40% reduction -- 20% from the loss of co-insurance, and 20% from reducing Medicare's allowable rate from 80% to 60% of the prevailing rate.

If the savings that were designed are being realized, they must be coming at the expense of the beneficiary, who is paying more money for laboratory testing done in physician office laboratories. We remind all concerned that the HCFA Laboratory Task Force's sole recommendation with respect to assignment was that "HCFA policy be uniform for both physicians and independent laboratories" (p.22). The HCFA Task Force warned that "If physicians are not required to accept assignment, they would continue to be able to pass on higher charges to beneficiaries than the Medicare program would recognize" (p.22). In addition, the Medicare program realizes savings because the deductible and co-insurance still apply on non-assigned claims. Therefore, program savings are accruing at the expense of the beneficiary, and to the advantage of the physician. We therefore recommend that changes be made which would require mandatory assignment for all providers of Part B laboratory supplier services; that the same standards for proficiency testing and personnel apply to all providers of clinical laboratory Part B supplier services; and that hospital outpatient laboratory services be included in the national fee schedule effective July 1, 1987. Then, and only then, will the rules be uniform and the fee schedule be most effective, as all of these requirements are interrelated.

I would like to reference two other points. First, several years ago the Health Care Financing Administration wanted to develop a model for "competitive bidding" for laboratory services. That proposal would have excluded all laboratories from Medicare reimbursement except the winning bidders. The HCFA

Task Force received this recommendation and concluded that there was a better alternative, namely the laboratory fee schedule that was enacted last year. The intent behind the laboratory fee schedule legislation was to establish a fee schedule which would make competitive bidding unnecessary.

Yet Mr. Chairman, while in the middle of trying to implement the fee schedule this past year (which we can tell you was revolutionary in nature and is still experiencing many difficulties) the Health Care Financing Administration came out with an RFP to develop a competitive bidding system for clinical laboratory services. We are not sure why. If there are underlying thoughts that Medicare is not getting the best price under the fee schedule, then perhaps we should review other reimbursement methods that can be considered within the fee schedule which will make the market price in some areas available to Medicare, but which would allow all providers to participate as they have since 1965.

We consider the publication of the competitive bidding RFP as a breach of faith by the Health Care Financing Administration. Against the recommendation of their own Task Force, and before the mechanics of the fee schedule have been fully implemented, HCFA is still going forward with the competitive bidding model. We have no other recourse but to enlist your assistance in helping us understand why the Health Care Financing Administration is taking this action after having supported and worked with us as recommended by the Task Force for the enactment of the fee schedule.

Finally, Mr. Chairman, in the Committee Report on the laboratory fee schedule there was a reference that the Health Care Financing Administration not disturb their existing practice of reimbursing laboratorians who service nursing home and homebound patients. This is referred to as a "trip fee", and carriers had reimbursed for the service prior to implementation of the laboratory fee schedule. However, the Health Care Financing Administration claims that this was a carrier policy and should not be continued under the laboratory fee schedule. The Health Care Financing Administration is still examining this policy, but it is not yet settled. The alternative, Mr. Chairman, is that the homebound or nursing home patient be transported, by ambulance or taxi, to an independent or hospital laboratory for their laboratory testing resulting in considerable additional expense for the Medicare program. Before the laboratory fee schedule the carriers reimbursed this trip fee to prevent the hospitalization costs and transportation costs. We thought this was clear in the Committee language, but as I have stated it has yet to be finalized by the Health Care Financing Administration. We request your support in clarifying this matter, either through the Department or in a legislative change.

Mr. Chairman, I want to thank you on behalf of the American Association of Bioanalysts for allowing us to present these matters to you for your consideration. We have attached to our statement some recommended changes, and I will be happy to answer any questions you may have at this time.



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REVISIONS TO MEDICARE'S PAYMENT FOR LABORATORY SERVICES

I. Uniform Assignment Policy

Prior to the Deficit Reduction Act (P.L. 98-369), Medicare policy concerning the acceptance of assignment for laboratory charges under Part B allowed physicians, hospitals, and independent laboratories to elect assignment on a case-by-case basis. The DRA included provisions that impose mandatory assignment on independent and hospital laboratories, but continue to allow physician office laboratory testing to be billed on either an assignment or non-assignment basis.

This new, uneven policy has had effects that are adverse to beneficiaries and unfair to hospitals and independent laboratories. Beneficiaries are at financial risk for the 20-percent co-payment when a physician does not elect assignment. In addition, except for the present freeze on charges, physicians who do not accept assignment may bill their patients customary charges that significantly exceed the fee schedule amount. In the future, this could result in a powerful financial incentive to physicians to perform laboratory services in the physician's office, and bill patients far more than Medicare will allow under its laboratory fee schedule.

Meanwhile, independent and hospital laboratories are at a competitive disadvantage by virtue of the requirement that they must accept assignment on all of their Medicare work. Further, the amount of payment to these laboratories is governed by the fee schedule which is set at 60 percent or 62 percent of the prevailing for independent and hospital laboratories respectively, while the physician who does not accept assignment may bill his customary charge.

RECOMMENDATION

Section 1833(h) (5) (c) should be amended to require that-
"Payment for a clinical diagnostic laboratory test may only be made on the basis of an assignment described in Section 1842(b) (3) (B) (ii) . . ."

II. Conditions for Laboratory Participation in Medicare

Under present law, independent laboratories are subject to extensive conditions of participation in order to be eligible for Medicare payments for the services they render. There are no conditions of participation related to services provided in a physician office laboratory that is operated for the patients of a physician and of his or her associates.

Given the increasing volume of outpatient laboratory services in physician offices, the trend for physicians to practice in larger and larger groups and the growing sophistication of this testing, it seems reasonable to apply Medicare laboratory quality standards to such services as well.

Because of diverse types and volume of laboratory activity being carried out in the physician office and the potential administrative burden on Medicare and state agencies under contract to Medicare, one step with minimal administrative burden would be to require all physician laboratories to participate successfully in a proficiency testing program that is either operated or approved by the state agency or by the Secretary. Such a program should cover all clinical laboratory and anatomical pathology specialties and sub-specialties in which the laboratory is engaged. This is one of the conditions presently imposed on independent laboratories.

In establishing a program of proficiency testing for laboratory services performed by, or under the supervision of, a physician for which services the physician bills, the Secretary would require periodic proficiency testing of varying degrees of challenge based upon scope and variety of such testing conducted or supervised by such physician.

The Secretary shall also establish a program of limited sample testing of the results of laboratory tests conducted by or under the supervision of all physicians who bill for such tests on an outpatient basis.

In carrying out the program of proficiency testing, the Secretary is authorized to contract with state or other recognized accredited testing bodies to conduct such testing.

RECOMMENDATION

Immediately following Section 1861(s)(10)(B), the material in the free-standing paragraph should be revised to delete the exemption of physician office laboratories from meeting standards imposed by state law and the Secretary.

III. Billing for Laboratory Services

As a result of the new, carrier-wide fee schedules for clinical laboratory services developed pursuant to P.L. 98-369, there is increasing attention to the differences in charges among these areas. One consequence of these differences is that a laboratory that performs services in more than one locality may be able to receive payments based either on where the test results are determined or on the location in which the patient specimen was obtained. Since these amounts will likely differ, given a choice, the laboratory can be expected to bill in the most remunerative jurisdiction.

This issue was clearly not anticipated in the enactment of the new provisions governing payment for laboratory services. Indeed, if there is a transition to a national fee schedule then this problem would be reduced to some extent (depending on how the national rate may be adjusted). In the interim, some policy needs to be applied to prevent laboratories operating over a wide geographical area from manipulating the billing procedure to produce payments that do not take into account, if lower, charges for such tests in the areas in which specimens were actually taken.

Until the advent of a national fee schedule, Medicare payment for laboratory services under Part B should be based on

the lower of the schedule in effect for the carrier area in which the test results are determined or the carrier area in which the specimen is obtained. Such policy would be consistent with Medicare prudent purchasing and would discourage large national laboratories from inappropriate manipulation of program payment policy. Alternatively, the fee schedule in effect in the area in which the laboratory is located could be used in all cases.

RECOMMENDATION

Section 1833(h)(7) - Insert a new paragraph as follows:

"In the case of clinical laboratories that perform tests for patients outside of the region, state-wide, or carrier service area (as determined by the Secretary), the applicable fee schedule for purposes of determining the reasonable charge shall be the lower of the fee schedule in effect for the area in which the specimen is obtained or the fee schedule in effect in the area in which the test is performed."



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Test of the Month

REGULATION OF PHYSICIAN OFFICE LABORATORY TESTING - June, 1985

By Mark S. Birenbaum, Ph.D.

Introduction

Clinical laboratories in the United States can be divided into three general categories: independent, hospital, and physician office laboratories. Of these three, the most heavily regulated is the independent clinical laboratory, which must meet specific quality control, proficiency testing, and personnel regulations to participate in the Medicare program. Hospital clinical laboratories must also meet quality control and proficiency testing requirements to participate in Medicare, but Medicare's personnel standards are not as stringent for hospital clinical laboratories as those for independent clinical laboratories.¹ On the other hand, physician office laboratories that perform laboratory tests on their own patients are exempt from Medicare regulations unless the physician office laboratory performs at least 100 tests per year on referral from other physicians.²

Recently, officials at the Centers for Disease Control (CDC) stated that "It has been estimated that perhaps 50% of all laboratory diagnostic tests in the United States are now being performed in approximately 40,000 physician office laboratories (7-10 billion tests annually)".³ In the opinion of CDC experts, physician office laboratory testing may become, if it isn't already, a primary sector for providing clinical laboratory tests in the United States.

While physician office laboratories are exempt from Medicare regulations, a number of states do regulate this major sector of the industry. To determine which states these are, and to examine the nature of their requirements, we surveyed each state for laws and regulations governing physician office laboratory testing.

Results

According to information received from public health laboratory directors in all fifty states, only thirteen states have specific laws or regulations governing physician office laboratory testing. Following is a list of these thirteen states and a brief description of the provisions governing physician office laboratory testing in those states:

*Member, National Commission for Health Certifying Agencies and the
National Council on Health Laboratory Services*

- CALIFORNIA - Physician office laboratories are exempt from the California laboratory licensure law, but must show satisfactory performance in an approved proficiency testing program in procedures which the physician office laboratory performs.
- FLORIDA - Laboratories maintained by groups of six or more physicians must be licensed and meet quality control, proficiency testing, and personnel requirements, and are subject to inspection.
- IDAHO - Physicians who physically perform the tests on his/her patients are exempt from the Idaho laboratory licensure law. Otherwise, physician office laboratories must meet proficiency testing and quality control requirements.
- MARYLAND - Laboratories maintained by groups of four or more physicians must be licensed and meet quality control, proficiency testing, and personnel requirements, and are subject to inspection.
- Groups of three or less physicians are exempt from the Maryland Laboratory Licensure Law but must satisfactorily participate in an approved proficiency testing program.
- Regulations are currently being revised.
- MASSACHUSETTS - Laboratories maintained by groups of three or more physicians must be licensed and meet quality control, proficiency testing, and personnel requirements, and are subject to inspection.
- Two classes of laboratory licensure exist, "Limited" and "Full". A limited laboratory license is issued to individuals who maintain a laboratory which performs only certain basic procedures which have been approved by the Massachusetts Department of Public Health.
- MICHIGAN - Laboratories maintained by groups of six or more physicians must be licensed and meet quality control, proficiency testing, and personnel requirements, and are subject to inspection.

- NEVADA - No requirements if physician personally performs a test or supervises performance of a limited number of tests, otherwise must register the laboratory, for which there are no specific requirements.
- NEW JERSEY- Physician office laboratories are not exempt from the New Jersey laboratory licensure law, but laboratory licensure requirements are not enforced (by Administrative Rule) for groups of four or less physicians.
- Regulations are currently being revised.
- OREGON - Laboratories maintained by groups of five or more physicians must be licensed and meet quality control, proficiency testing, and personnel requirements, and are subject to inspection.
- PENNSYLVANIA - Level I Laboratories: must be registered, for which there are no specific requirements.
- Level II Laboratories: must be registered, participate in an approved proficiency testing program, and meet quality control requirements.
- Level III Laboratories: must be licensed under the Pennsylvania laboratory licensure law and meet quality control, proficiency testing, and personnel requirements, and are subject to inspections.
- WEST VIRGINIA - No laws or regulations except for premarital and prenatal Syphilis testing.
- To participate in West Virginia's Medicaid program two levels of physician office laboratories are defined: "Basic" laboratories, which are those that perform only blood glucose, urinalysis, hemoglobin, hematocrit, pregnancy testing, gram stain, and examination of stool specimens for occult blood. "Extended" laboratories perform tests besides the ones listed above.
- Basic and Extended laboratories must satisfactorily meet quality control, proficiency testing, and personnel require-

requirements, and are subject to inspection.

WISCONSIN -

Laboratories maintained by groups of three or more physicians must be licensed and meet quality control, proficiency testing, and personnel requirements, and are subject to inspection.

WYOMING -

Licensed required of all physician office laboratories.

Proposed regulations would establish three levels of laboratories with the following requirements:

Level I: No requirements

Level II: Must participate in an approved proficiency testing program.

Level III: Must have independent laboratory license and meet quality control, proficiency testing, and personnel requirements, and are subject to inspection.

Laws and regulations in these thirteen states vary significantly, from registration in Nevada for which there are no specific requirements, to quality control, proficiency testing and inspection in Idaho if the physician does not physically perform the test. A number of states exempt some group practices of physicians from state laboratory licensure laws. For example, in Michigan five or less physicians, in Oregon four or less physicians, and in Wisconsin two or less physicians doing work on their own patients are exempt from the state laboratory licensure laws.

In New Jersey physicians are subject to the state laboratory licensure law, but the state, by administrative rule, does not enforce the law for physicians in groups of four or less. The Wyoming laboratory licensure law, passed in 1977, requires physician office laboratories to be licensed but the regulations to implement the law have still not been adopted.

Other states have developed a "tiered" system of regulating physician office laboratories. In this system, levels of regulations for physician office laboratories are specified according to the types of laboratory procedures performed. In Massachusetts, physician offices with a

"limited license" must participate in a proficiency testing program and maintain quality control. A specific list of procedures defines those laboratories eligible for the limited license. In Pennsylvania there are three levels, defined by specific laboratory procedures. Physician office laboratories performing Level I tests must be registered, for which there are no specific requirements. Level II physician office laboratories must be registered, participate in an approved proficiency testing program, and maintain quality control. Level III physician office laboratories must meet quality control, proficiency testing, and personnel requirements, and are subject to inspection. A similar "tiered" system is being considered in Wyoming. The Wyoming proposal varies from the Pennsylvania model as to which laboratory tests define the three levels.

And finally, California physician office laboratories must show satisfactory performance in an approved proficiency testing program.

Conclusion

Thirty-seven states do not regulate physician office laboratory testing. In the thirteen states that do, the level of regulation varies significantly.

Discussion

In states with regulations, the extent of enforcement of the laws/regulations is in doubt. Some state regulatory officials from highly populated states indicate that effective enforcement of the regulations is lacking. Others report that enforcement is achievable and is being successfully carried out.

References

- 1 Report of the HCFA Laboratory Task Force, February 15, 1984, p. 4.
- 2 Federal Register, vol. 39, No. 183, September 19, 1974, p. 33692
- 3 Federal Register, vol. 50, #107, June 4, 1985, p. 23518.



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PROJECTIONS OF MEDICARE EXPENDITURES FOR PART B CLINICAL LABORATORY SERVICES FROM FY 1984 TO FY 1986

Even prior to the enactment of the Deficit Reduction Act of 1984, the Health Care Financing Administration's (HCFA's) Laboratory Task Force reported that "it is also widely acknowledged by ... manufacturers and independent laboratory owners and corporate officials that physician office laboratories are the most rapidly growing segment of the market supplying lab tests."¹

Following enactment of the Deficit Reduction Act of 1984, financial incentives for physicians to perform laboratory testing in their own offices increased, resulting in a sharp increase in sales of laboratory equipment to physician office laboratories. More recently, officials from the Centers for Disease Control (CDC) in Atlanta stated that "It has been estimated that perhaps 50% of all laboratory diagnostic tests in the United States are now being performed in approximately 40,000 physician office laboratories (7-10 billion tests annually)."²

Medicare laboratory expenditures are also projected to increase dramatically for laboratory testing performed by physician office laboratories. According to the 1984 HCFA Laboratory Task Force report, approximately \$1.6 million in FY

1984 was spent by Medicare for non in-patient diagnostic laboratory services under Part B. Of this amount, approximately 50%, \$800 million, was paid to hospitals for non in-patient testing. The remaining \$800 million was paid to independent laboratories and physicians.³

In order to project the changes in Medicare Part B expenditures for laboratory diagnostic testing, it is necessary to convert the figures reported by HCFA prior to July 1, 1984 to a form which can be easily compared with data obtained subsequent to July 1, 1984. To do that, one must calculate the amount of dollars allocated by Medicare for services actually performed in physician office, hospital, and independent clinical laboratories. This calculation is complicated because prior to July 1, 1984, physicians could bill Medicare for work which was referred to independent or hospital laboratories. This option was eliminated by the Deficit Reduction Act.⁴

According to a May, 1983 report from the HCFA Region V Office, on average only one out of every four clinical laboratory procedures ordered by the physician was actually done in the doctor's office, with the remaining three laboratory procedures being referred to an independent clinical laboratory for processing.⁵

Therefore, of the approximately 80% of laboratory procedures ordered by physicians, roughly three-fourths were performed by independent laboratories. In actuality, only 20% of laboratory tests were performed by physician offices, and

80% were performed by independent laboratories. This result is consistent, but a bit higher than, estimates based on data from Rhode Island, a state which prohibited physicians from billing patients for laboratory tests actually performed in an independent laboratory. In Rhode Island approximately 65% of non-hospital laboratory tests were billed, and thus presumably performed, by independent laboratories, with the remaining 35% billed by physicians.⁶

Assuming that the number of laboratory tests ordered is proportional to Medicare payments for those tests, yields the following results: 80% of \$800 million equals \$640 million, which represents total Medicare Part B payments for laboratory work actually performed in independent laboratories in FY 1984. The remaining \$160 million, or 20%, represents total Medicare Part B payments for work actually performed in physician office laboratories in FY 1984.

It is important to remember that the \$800 million paid by Medicare for Part B diagnostic laboratory services performed by independent laboratories and physician office laboratories does not represent the total income to those entities for performing those same tests. Prior to the enactment of the Deficit Reduction Act, Medicare paid 80% of the prevailing charge, allowing the provider of laboratory tests to collect a 20% co-insurance payment from the Medicare beneficiary. Therefore, independent and physician office laboratories were entitled to at least \$200 million in additional payments (from Medicare beneficiaries) for laboratory services provided to Medicare

patients in FY 1984. Physicians and independent laboratories (as well as hospital laboratories) may have even collected additional income because assignment was not mandatory, and payments on unassigned claims could have been higher than the Medicare prevailing charge levels.

HCFA's Office of Financial and Actuarial Analysis projects total Medicare Part B laboratory expenditures in FY 1985 as \$1.8 billion, and \$2.1 billion in FY 1986. Additionally, the same office projects payments to independent laboratories for Medicare Part B diagnostic laboratory services as \$500 million in FY 1985, and \$583 million in FY 1986.⁷ Assuming that hospital laboratory testing continues to account for approximately one-half of all Medicare Part B expenditures, it is possible to project the total amount of Medicare payments in FY 1985 and FY 1986 to physician offices for work actually performed in physician office laboratories. In FY 1985, this calculation yields a total payment of \$400 million, and \$467 million in FY 1986 (see Figure 1). These percentages might be expected to change somewhat following enactment of the Deficit Reduction Act, but the expected change would probably result in a lower percentage of tests actually performed by independent laboratories because of the noted trends about the increase of testing done by physician office laboratories. Therefore, the projections in Figure 1 may represent an underestimate of the total payments for physician office laboratory services, and an overestimate of payments for independent laboratory services.

The projections yield some interesting results. For example, total payments for services provided by independent laboratories actually decrease in FY 1985 by approximately 22%. On the other hand, payments for services provided by physician office laboratories increase by approximately 150%, from \$160 million to \$400 million in FY 1985. Over a two-year period payments for independent laboratory services decrease slightly, by approximately 9%, from FY 1984 levels. Payments for physician office laboratory services increase by nearly 192% over the same two year period.

Medicare Part B payments for diagnostic laboratory services provided by hospitals are also projected to increase significantly over the two-year period, from \$800 million to \$1.050 million, an increase of over 31%, assuming hospital laboratories continue to receive 50% of Medicare Part B payments for laboratory services.

Conclusions

Financial data from the 1984 HCFA Laboratory Task Force Report and from HCFA's Office of Financial and Actuarial Analysis project increases in payments for Medicare Part B diagnostic laboratory services in FY 1985 and FY 1986. However, payments for services provided by different segments of the laboratory industry vary dramatically. Total Medicare Part B payments for independent laboratory services are projected to decrease by approximately 9%, whereas payments for hospital laboratory services will increase by approximately 31%, and

payments for physician office laboratory services by approximately 192%.

Total income for Medicare non-inpatient laboratory procedures received by independent and hospital laboratories is equivalent to total projected Medicare Part B expenditures because assignment is mandatory for those sectors of the industry.

On the other hand, total income to physician offices is greater than Medicare Part B expenditures because physicians may still choose to accept assignment on a case-by-case basis.

Discussion

Efforts to control escalating costs for diagnostic laboratory services must be directed at the sectors of the industry in which these increases are occurring. Therefore, cost containment efforts should be directed mainly at physician office laboratories and at hospital laboratories.

FIGURE 1

	TOTAL PAYMENTS	TOTAL PAYMENTS	TOTAL PAYMENTS	TOTAL PAYMENTS
	For	For Work	For Work	For Work
	Non-Inpatient	Performed In	Performed In	Performed In
	Lab. Services	Indep. Labs.	Phys. Offices	Hosp. Labs.
<hr/>				
FY 84	\$1.6 billion	\$640 million	\$160 million	\$800 million
FY 85	\$1.8 billion	\$500 million	\$400 million	\$900 million
FY 86	\$2.1 billion	\$583 million	\$467 million	\$1,050 million

Projections are based on data from the "Report of (HCFA's) Laboratory Task Force", February 15, 1984 and projections from HCFA's Office of Financial & Actuarial Analysis.

Footnotes

1. Report of the HCFA Laboratory Task Force, February 15, 1984, p. 4.
2. Federal Register, vol. 50, #107, June 4, 1985, p. 23518.
3. Report of the HCFA Laboratory Task Force, February 15, 1984, p. 5.
4. Deficit Reduction Act of 1984, June 23, 1984, Report 98-861, p. 599.
5. Diagnostic Clinical Laboratory Services in Region V, #2-05-2004-11, May, 1983, p. 4.
6. Report of the HCFA Laboratory Task Force, February 15, 1984, p. 5.
7. National Intelligence Report, vol. VI, No. 10, March 12, 1985, p. 1.

Mr. WAXMAN. I am going to look forward to reading the second point that you never got to.

Mr. Linden.

STATEMENT OF SANFORD J. LINDEN

Mr. LINDEN. Thank you, Mr. Chairman.

My name is Sanford Linden. I am the president of the National Association of Medical Equipment Suppliers.

I would like to begin by saying that we support the administration's budget proposal to freeze and index durable medical equipment rental charges as part of the overall effort to reduce the budget deficit. However, the effect of the budget freeze must be considered in light of three major policy reimbursement initiatives for Medicare DME that were recently introduced and implemented by HCFA. This is oxygen coverage guidelines, oxygen reimbursement, and the rent purchase payment procedures.

Let me tell you a little bit about our business, what we do. In 1966 when you thought about renting durable medical equipment in the home, you thought about a wheelchair, possibly oxygen, possibly some other piece of equipment that was pretty foreign to these people, especially senior citizens over the age of 65.

Over the years what seems to have happened is that we became problem solvers. We certainly saw in our medical schools that they were not teaching curriculums that included wheelchairs and what types of equipment are needed. We also saw the hospital discharge planners and social workers really started relying on us to be problem solvers, to say, in a sense, we have this patient that has to go home, we don't know what they need, the doctor has written this particular prescription, please handle it from here.

We have gotten very good at it. The problem now comes in under the rental-purchase guidelines that HCFA has proposed and mandated for us. I can tell you that in 1977 when the law was first passed, and then again in 1980 when the regulations came down from HCFA, we were very concerned because we looked at where the regulations were going to put our patients and where the dollars were going to be spent, and we saw that of the three studies, the Williams College study and two different GAO studies which were funded by the government, that actual rent-purchase was not going to save dollars. They were not the answer to the problem that we have upon us today.

I think we are seeing now truly where the real bad part is to the beneficiary because basically what is happening now is that the beneficiaries cannot improve their condition without getting a different piece of durable medical equipment. They cannot do the service themselves in the home. They don't understand the equipment.

We now have equipment that is being provided, from very sophisticated high technology type of ventilators, which I can assure you that if there is a mistake in terms of condition, that person is not going to have a future with us. There are high tech types of nutrition systems, therapy systems that are in the home right now that need service, that need maintenance. We are the experts.

Under the rent-purchase guidelines, we are supposed to make a decision within the first couple of months whether or not that piece of equipment should be purchased or should be rented. We cannot do that. A condition does change to the point where you need a piece of equipment for more than two or three months at one time. The condition may get worse, it may get better, but you may need that type of leeway.

In addition, our business has become one where we need total maintenance. We have total 24-hour recall. We have a total type of service to the patient that we take away from this. If we freeze these purchase prices, we will be doing a great injustice to the patient.

I would like to give you an example. You have a piece of equipment that costs \$500. That piece of equipment has been rented for 2 months, and now the decision has been made, because that piece of equipment is going to be needed for a greater length of time, let's purchase that. You no longer have the assignment rate of 96 percent which we get on rentals, but the purchase assignment rates are somewhere around 30 percent, because there has never been a purchase history in our business. We have always been a rental business. We have always been relied upon to take care of the service and maintenance of all of our equipment; hence, the histories that have been built up in the carrier community are those of rental prices.

We do feel we can do our part by freezing those rental prices, but to come in right now and put a freeze on purchase prices that are totally inaccurate, that are totally unfounded, would be a terrible injustice, and I can guarantee you that that 33 percent assignment rate can do nothing but go down.

I think we have a responsibility in this room to make the proper fiscal decisions, not just based on money, but based on the entire concept that DRG's are bringing people out of the hospitals faster. They are going into the home. Who is going to take care of these people in the home, if the systems that are set up in place are not allowed to prosper?

I think a final point I would like to make, if we are in the position now where we are taking care of people—and we truly are—then we would like to be a part of the health care delivery system. That includes everything we are doing in the home.

Thank you, Mr. Chairman.

[Testimony resumes on p. 656.]

[The prepared statement of Mr. Linden follows:]

STATEMENT OF NAMES
BEFORE THE
HOUSE ENERGY AND COMMERCE SUBCOMMITTEE ON HEALTH

Thank you, Mr. Chairman, for allowing the National Association of Medical Equipment Suppliers (NAMES) to present its views regarding the effects of the Administration's budget proposals on the Medicare program. My name is Sanford J. Linden. I am President of NAMES and owner of Linden Home Health Care, Inc., Southfield, Michigan.

NAMES, with a membership of over 1,400, is the largest trade association representing home care medical equipment suppliers throughout the country. Our members serve over 2 million patients who are able to avoid institutionalization because of the availability of medical equipment ranging from walkers and wheelchairs to oxygen-related items to high tech nutritional therapy. Home care equipment suppliers provide not only the equipment but also the services that are essential to assure proper functioning and use of the equipment in the home. Most NAMES members serve Medicare beneficiaries.

I. NAMES SUPPORTS A DME FREEZE

Mr. Chairman, NAMES supports the Administration's budget proposal to freeze the customary and prevailing rental charges for durable medical equipment (DME) beginning in fiscal year 1986. We have not seen the actual proposed budget legislation. Therefore, we are not sure what is proposed to be frozen. Mr. Chairman, NAMES supports a

freeze that applies to the lower of the supplier's data-generated customary charge or the 75th percentile of the data-generated customary charges for all suppliers in a given locality. This is referred to as the reasonable charge methodology and is set out in Section 1842 B of the Medicare statute.

The budget freeze proposal has been construed as a limit on increase. However, a true freeze would assure that prices cannot be lowered or raised.

Oxygen Reimbursement. HCFA implemented on April 1, 1985, a nationwide system of limiting Medicare payment for oxygen under the DME benefit. The HCFA initiative (PATROL Transmittal No. 18-3) directs carriers to pay for all oxygen at a standard per cubic foot rate. This PATROL initiative was not subject to notice and comment through Federal Register publication or any other outside input. HCFA expects this initiative to achieve savings for Medicare. However, it may also cause beneficiary hardship particularly because of the confusion in establishing a fair price for portable gaseous oxygen. NAMES has requested along with doctors, manufacturers, and beneficiaries that HCFA direct carriers to establish a separate pricing method for portable oxygen cylinders.

Unlike portable liquid oxygen systems, portable gaseous oxygen cylinders cannot be transfilled in the home due to extraordinary fire and explosion hazards associated with high pressure cylinders. There are extensive federal regulations and industry safety procedures which must be met to transfill gaseous cylinders. It is beyond the technical

and financial ability of most Medicare beneficiaries to meet these requirements and is certainly an error for HCFA, as a matter of policy, to establish reimbursement rates on the assumption that a beneficiary can transfill in his home.

While NAMES supports efforts to achieve a reasonable balance in oxygen payment, reimbursement policy should not be used to restrain utilization — coverage guidelines serve that purpose. Reimbursement for portable gaseous oxygen which is substantially lower than market prices is a barrier to beneficiaries' access to necessary and appropriate portable gaseous oxygen, as demonstrated in HCFA Region IV.

Oxygen Coverage — The April 5, 1985, publication by HCFA of a final notice on oxygen coverage guidelines may result in reduced utilization of oxygen and, therefore, may result in additional Medicare savings. The oxygen coverage guidelines establish uniform, nationwide criteria which a beneficiary must meet to receive Medicare oxygen benefits. NAMES supports such an effort to bring predictability and consistency to oxygen coverage determinations.

Rent/Purchase — HCFA implemented on February 1, 1985, the DME rent/purchase guidelines. These carrier guidelines drastically revise the method for determining payment for DME by requiring purchase rather than rental. A closer examination of the data from the GAO's draft report reveals quite different savings outcomes for expensive and inexpensive DME. Therefore, at the outset we must distinguish between

the rent/purchase policy change for inexpensive equipment (costing less than \$120.00) and expensive equipment.

HCFA's action on implementing rent/purchase payment for inexpensive DME seems appropriate because it is likely to: 1) reduce Medicare outlays, 2) not increase claims administration expenses, 3) not disrupt the Medicare beneficiary benefit for DME and, 4) resolve abuses of long-term rentals of inexpensive equipment. NAMES has supported such action since 1982.

By contrast HCFA's action which increases purchase of expensive equipment (costing more than \$120) is an egregious error because, according to the HCFA-Williams College and GAO reports it is likely to: 1) not reduce Medicare outlays, 2) increase claims administration expenses and 3) disrupt beneficiary service by eliminating routine maintenance and the DME benefit. Therefore, Congressional attention at this time must focus on HCFA's action on Medicare payment for purchase of expensive DME.

NAMES long-time position has been that reimbursement for items costing \$120 or less should be limited to the purchase price. In addition, NAMES developed an alternative reimbursement formula for expensive equipment designed to eliminate abuses while recognizing the fact that the DME industry is labor intensive, service and maintenance oriented. The acquisition cost of DME is only a small percentage of the total cost of doing business. The NAMES payment alternative has been communicated to both the Congress and HCFA many times over the last two years.

Implementation of the rent/purchase guidelines for expensive DME has not gone well. Despite HCFA's claims that Medicare carriers and the DME industry have had two or three years to prepare for implementation — the plain fact is that carriers, beneficiaries and suppliers were unprepared. Today, more than five months after implementation, every DME supplier is uncertain about how his Medicare claims will be processed, what price will be used and when he will be paid.

It is not just a few inefficient carriers who are having trouble — all carriers are having difficulty with implementation of DME rent/purchase guidelines. The problem? Unclear, inconsistent and ambivalent instructions and directions from HCFA.

NAMES, carriers and HCFA have been working together to develop clear and consistent implementation instructions. However, many of these implementation issues have been around since 1980 when the rent/purchase regulations were published. The prospects for clarity and consistency are dim without substantive changes in the statute. HCFA's decision to put a moratorium on oxygen equipment a month and a half after implementation illustrates the underlying problems. Paying only for the product without consideration for service needed to maintain the equipment in the home is shortsighted and leaves the beneficiary at great risk.

Despite these implementation problems and uncertainties, we feel it is important to note that beneficiaries have thus far been shielded from any uncertainty or anxiety related to their Medicare DME benefit.

This is due to the professionalism and sincere care that home care DME suppliers provide Medicare beneficiaries.

As you can see from these examples, HCFA has made significant adjustments to the Medicare DME benefit in an extremely short period of time -- any one of which is as significant to DME suppliers as the shift in hospital payment to DRGs. There are additional administrative actions currently under consideration by HCFA that would have an additional impact on the DME and other Part B services. These include parenteral/enteral nutrition reimbursement, arbitrary reduction in rental charges to 1/10 of purchase charges and arbitrary reduction in oxygen concentrator charges.

It is important to note that none of these administrative initiatives as described above are subject to administrative or judicial review.

II. ESTABLISH REASONABLE AND FAIR PURCHASE CHARGES

As a result of the rent/purchase guidelines implementation, most carriers are, for the first time, developing prevailing charges for purchase of used equipment and prevailing charges for purchase of new equipment. If purchase charges are frozen, it could create severe hardships for both beneficiaries and suppliers. HCFA has recognized this problem and instructed carriers to closely examine profile purchase charges to determine if they are significantly lower than marketplace charges and make necessary upward adjustments where appropriate. NAMES, therefore, urgently requests that this committee

ensures that any freeze proposal takes this uncertainty into account. Because virtually all beneficiaries choose to rent rather than purchase equipment, carriers have not had sufficient historical submitted charge data to establish purchase prevailing charges. Moreover, carriers that have established new equipment prevailing purchase charges for certain equipment have mixed submitted purchase charges for used and new equipment, as well as non-commercial (i.e., beneficiary to beneficiary) sales. Therefore, virtually all prevailing purchase charges for new equipment are significantly lower than marketplace prices.

HCFA instructed carriers to arbitrarily establish used equipment purchase prevailing charges at 75% of the new equipment purchase prevailing charge. In other words, 75% of an incorrect charge. There is no statutory basis for HCFA to arbitrarily set used prevailing charges at 75% of new prevailing charge and NAMES has vigorously opposed such action.

HCFA's recently implemented rent/purchase guidelines for Medicare DME payment provide an incentive — waiver of coinsurance and 100% payment — for a DME supplier submitting charges for purchase of used equipment at 75% (or less) of the new equipment reasonable charge for the same item. A subsequent HCFA instruction directed carriers to arbitrarily establish used equipment purchase prevailing charges at 75% of the new equipment purchase prevailing — effectively eliminating the waiver incentive, not allowing "market" behavior to occur and imposing an unfairly-low payment level.

NAMES supports the incentive provision contained in the statute at 75%. We oppose establishing the used purchase prevailing at that same

level (i.e., 75% of the new purchase prevailing charge). HCFA's apparent reason for using 75% to arbitrarily set used purchase prevailing charges is to protect the beneficiary. However, the beneficiary is harmed, not protected, because his or her choices are decreased. There is no increase in Medicare DME outlays if the used purchase prevailing charge is set at a higher amount, for example 90% rather than 75% of the new equipment purchase level. In fact, there may be additional savings to the Medicare program.

Furthermore, if 90% rather than 75% is used, the beneficiary (particularly a beneficiary with supplemental insurance) would have an opportunity to purchase a higher valued item — and have the supplier take assignment. For example, a supplier may have in his or her inventory two used hospital beds. One is two months old, the other two years old. The supplier purchase price for the two-month-old bed is \$900.00 while the two-year-old bed is \$750.00. If the used purchase prevailing is set at 90% (e.g., \$900.00), rather than 75% (e.g., \$750.00), the beneficiary has the opportunity to purchase either bed and have the supplier take assignment on either choice. The beneficiary that could not afford or does not have supplemental insurance for the coinsurance amount could select the \$750.00 bed and the supplier under assignment would receive the full amount and not have to collect coinsurance from the beneficiary.

By contrast, if the used purchase prevailing is set at 75%, (e.g., \$750.00) as the guidelines currently require, the beneficiary that selects that \$900.00 bed would have to pay the supplier the full amount on his own because the supplier would not take assignment.

III. IMPACT OF RECENT HCFA ACTIONS ON DME BENEFIT

Mr. Chairman, the Congress and your committee should be apprised of the impact on assignment, quality and service within the Medicare DME benefit that results from the cost containment actions already taken by HCFA (i.e., oxygen reimbursement, oxygen coverage, rent/purchase payment). Summarized below are the possible effects:

Assignment — Traditionally, Medicare beneficiaries have enjoyed a very high rate of assignment by DME suppliers. The February 13, 1985, draft General Accounting Office (GAO) report on durable medical equipment indicated that for the carriers GAO reviewed, the percent of rental claims assigned was 96.4 while the percent of purchase claims assigned was 32.8. One reason for the lower assignment rate for purchase may be that purchase prevailing charges were unacceptably low. Therefore, with the implementation of rent/purchase payment, which increases the incidence of purchase, with the carriers establishing purchase prevailing charges, and with the reduction of prevailing charges for oxygen equipment, it is likely that a decrease in the percentage of assigned claims will result.

Quality of Product — HCFA implementation of rent/purchase for expensive equipment (equipment costing more than \$120) creates a powerful incentive to provide the least expensive product possible for

purchase. The DME industry strongly objects to this incentive because the lower cost equipment is usually lower quality and the beneficiary and the Medicare program will bear this burden. Under rental, the DME supplier has an incentive to maintain quality products which remain in service for a long period of time. This contrasts with purchase where the low Medicare prevailing charges force the supplier to cut costs by providing lower cost — therefore lower quality — equipment. Lower quality equipment has a shorter product life, requires more repair and maintenance and may result in increased Medicare outlays under purchase.

This was demonstrated in a November 1984 Congressional Office of Technology Assessment case study which found that 1) the emphasis on price over performance in the reimbursement procedure has probably discouraged innovation, 2) cost comparisons are more meaningful if "total annualized costs," which includes maintenance and repair, are computed, 3) encouraging innovation may result in lower annualized costs. Neither the GAO report nor HCFA's assessment of the rent/purchase payment procedure includes this analysis.

Service, Repair and Maintenance — Essential to the provision of DME in the beneficiary's home is the service which is necessary to keep the product, whether life-support or other DME, operating. Clearly the level of service varies according to equipment needs and beneficiary usage. Generally, the current rental charges reflect this variance while purchase charges do not.

The beneficiary, prescribing physician and referral source recognize the medical necessity of having the equipment delivered to

the patient's home. Under current hospital discharge pressure, this delivery may be required at any time (e.g., weekends, evenings) and the request for the equipment is frequently on very short notice. The supplier distribution network accommodates timely delivery. In addition, subsequently required necessary disposable supplies are delivered. Current Medicare rental charges take delivery costs into account, while most purchase charges do not.

After delivery to the patient's home, the equipment must be set-up and put in good working condition. This often requires more than simply unboxing a product and checking to see if it is working properly (calibration, etc.). For example, over 200 varieties of wheelchairs are available. The DME supplier uses his professional judgment to select the best product and make the necessary adjustments to meet the beneficiary's individual medical needs.

A thorough understanding of the equipment by the beneficiary is necessary to achieve the proper medical benefit from the equipment. Often this requires that the supplier repeat daily the instructions to the beneficiary and his family, followed-up with periodic inquiries to assure that the beneficiary is using the equipment properly. Like the first days at home with a new baby, the first days at home with new equipment are more difficult and require more intense training and attention. Ongoing training is as important as the initial training.

24 hour service - As already discussed above, the initial delivery may be required at any time. This requires 24 hour service and an emergency phone line by the DME supplier. More important, however, is

the need while the patient is using the equipment, for immediate response to service needs. The supplier has a strong incentive to provide 24 hour service to solve problems with equipment under rental. There is no incentive for 24 hour service under purchase.

Maintenance - As noted in the preceding examples any maintenance required to keep the equipment operating efficiently is covered under the Medicare rental. Most suppliers schedule periodic visits to provide routine maintenance on equipment in addition to responding to user needs for maintenance. Under purchase, Medicare would not pay for routine maintenance so the likelihood of optimum performance and useful life of the equipment is diminished.

Calibration - Certain equipment (e.g., oxygen concentrator, TENS) must be periodically calibrated to assure proper functioning of the equipment. If the equipment is rented, such calibration, like routine maintenance, would normally be performed on a regular schedule. There is no provision for Medicare payment for calibration if the equipment is purchased.

IV. ABSENCE OF REVIEW OR APPEAL

Mr. Chairman, NAMES supports H.R. 2864, the Fair Medicare Appeals Act of 1985 which would allow providers to represent beneficiaries and to provide for administrative and judicial review of determinations under the Medicare Part B program.

When the Medicare Part B program was founded, it was intended to be a supplement to the Part A program and to deal with somewhat trivial matters which could be handled by hearing officers employed by the

carriers. For this reason, judicial review was considered unnecessary. Medicare regulations governing the authority of the hearing officer and recent court cases have further narrowed the review process.

The Medicare Part B program of 1985 covers many areas of health care, some of which are far from trivial. Under the new prospective payment system, more care is being provided in a Part B home care setting and more patients are using life support services in the home. At the same time, more policy statements which affect millions of Medicare beneficiaries are issued by HCFA without notice and are being developed without the right to any form of a hearing.

The time has come for the Medicare Part B program to be on an equal footing with the Part A program. Provisions must be made for administrative and judicial review of HCFA determinations. Medicare regulations currently require the hearing officer to comply with not only laws and regulations, but all policy statements, instructions and other guides issued by HCFA. These policy statements, instructions and guides comprise the heart of the Medicare Part B program, constitute literally thousands of pages of documents, but are neither subject to the Administrative Procedure Act nor review by hearing officers or courts. Where the hearing officer does have authority to review a matter, he does not have subpoena power or the power to compel the carrier to respond to questions.

V. CONCLUSION

The elderly have been subject to significant changes due to the recent HCFA initiatives to reduce costs for Medicare DME — oxygen coverage, oxygen reimbursement, rent/purchase payment for inexpensive equipment. Problems with the purchase charges for new and used equipment need immediate attention. This is because, until the implementation of rent/purchase payment, there simply were no, or very few, customary or prevailing purchase charges. Congressional action on expensive DME should focus on the NAMES alternative payment proposal. The recent draft GAO report demonstrated, unlike HCFA's rent/purchase instructions for expensive equipment, that the NAMES alternative would result in savings to the Medicare program.

VI. RECOMMENDATIONS

- . Consider the significant changes affecting beneficiaries receiving DME that have resulted from the policy changes recently implemented by HCFA.
- . Consider the need to first establish fair and reasonable purchase charges for DME before freezing those charges.
- . Consider the savings that would be achieved by withdrawing the HCFA rent/purchase payment instructions for expensive equipment and substituting the NAMES alternative payment proposal.
- . Consider the need for Congress to provide review and appeal for Medicare Part B beneficiaries and providers.

Mr. WAXMAN. Thank you very much. Let me thank the three of you for your testimony. You have given us some good points to consider as we look at the legislation next week.

Mr. Whittaker.

Mr. WHITTAKER. I have no questions, Mr. Chairman.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

Ms. Park, if we don't have a freeze with respect to laboratory services, what would be the problem with a modification of the extreme high sides of the fee schedule? I touched earlier on this, and I think the chairman has as well.

There are tremendous variations in the local fee schedules currently in effect. We have got data that show variations on the order of 200 to 300 percent for some of these procedures. Many of them are high-volume tests done on automated equipment.

First of all, why not some modification in the extreme high sides of the fee schedules?

Ms. PARK. Like Dr. Davis said this morning, my personal feeling is, let's don't tinker with the system just when you're into it. I think there are reasons for inequities in the fee schedule.

No. 1, I am certain that it is more costly to live in Congressman Waxman's area than it is to live in Nashville, TN, and these are all forces of the market.

Mr. WYDEN. 300 percent more costly?

Ms. PARK. I would probably think it is pretty close to that. Also—

Mr. WYDEN. Could you give us some evidence? Things like wage differentials and things that specifically relate to this question that warrant that 300-percent difference between one part of the country and another.

Mr. WAXMAN. Can we have it by ZIP Code, too?

Mr. WYDEN. By Democrats and Republicans.

Ms. PARK. You have to keep in mind that these were based on reasonable charges, correct? And this is market-driven.

Mr. WYDEN. Tell us about market driving. You used that word in your testimony. What are these market realities that justify a 300-percent price differential?

[Pause.]

Mr. WYDEN. What are these market realities that warrant that 300-percent price variation that exists?

Ms. PARK. Would you like to answer that, Hope?

Ms. FOSTER. We're talking about the cost of doing business. Certainly we're talking about wage differentials. In response to your question about data supporting the question of whether wage differentials are 300-percent, there are 300-percent variations in various geographic areas. We do not have that information, Congressman, nor can I get it. I cannot tell you whether wage differentials justify a 300-percent variation of fee schedule.

I can say that in shopping for real estate in various parts of the country, I have seen differentials that exceed those types of differentials and can assume that they—those variations are reflected in a variety of other costs that laboratories incur. Obviously not real estate costs necessarily, but a variety of them.

But I do not have the wage information you ask for.

Mr. WYDEN. We will show you the data that we have picked up, as I understand it, and if you all can give us some good reasons—wages or cost of living or—

Ms. FOSTER. I would be happy to.

Mr. WYDEN. Just living high on the hog in Congressman Waxman's district.

We would be interested.

Ms. FOSTER. I do understand that California fee schedules are high, but I am told by those who do business in the State that it is an expensive State to do business in. I am sure Congressman Waxman agrees with that.

The other thing I would suggest is that it is very difficult to respond to a notion that is expressed in very general terms. I do not know how ACLA would respond to a specific proposal with regard to modifying the top of the fee schedule. The proposal that we had heard about sounded quite extreme to us. It was based on a determination of medians—115 percent in the first year, 110 percent in the second year—and I must tell you, that seems quite extreme, and I do believe that the wage variations in the country probably exceed that type of proposal.

Now if we can sit down and talk about something other than that or whatever it is specifically that it is that you are envisioning with regard to modification of the high end—

Mr. WYDEN. We are not envisioning anything at this point. I just wanted to hear an explanation for what struck me as very remarkable variations.

Ms. FOSTER. It is also possible that the low-end fees could be too low, based upon either inaccurate calculation on the part of the carriers or highly competitive markets that force prices down below where they might appropriately be or the failure of HCFA to follow the instruction of the conference committee when it directed carriers in direct-billing States as to how they ought to be calculating fee schedules.

Mr. WYDEN. Mr. Chairman, can I ask unanimous consent for one other very short question?

Mr. WAXMAN. Without objection.

Mr. WYDEN. Ms. Park, you also said that physicians with their own labs overutilized tests. Do you have any data which indicate that?

Ms. PARK. Yes. Attached is the Michigan study, and also there is a region V study that we would be happy to provide you with. The Michigan study demonstrates that—it is a considerable percentage higher. But it is the last attachment to the statement.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Wyden.

And thank you for your testimony. You have me talking with a southern accent.

Ms. PARK. Oh, good.

Mr. WAXMAN. We will be glad to work with you as we prepare legislation.

That concludes our hearing. We stand adjourned.

[Whereupon, at 6:22 p.m., the hearing was adjourned.]

[The following letter was submitted for the record:]



American College of Surgeons

FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA, 1913

55 EAST ERIE STREET CHICAGO, ILLINOIS 60611 AREA CODE 312 • 664-4050

C. ROLLINS HANLON, M. D., F. A. C. S.
DIRECTOR

July 25, 1985

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health and the Environment
House Energy and Commerce Committee
United States House of Representatives
2415 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed is the statement of the American College of Surgeons concerning second surgical opinion programs. These programs are among the deficit reduction proposals that would affect Part B of the Medicare program. We request that this statement be made a part of the record of the hearings held on July 17, 1985.

The American College of Surgeons is a voluntary educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of high quality care for the surgical patient. The College provides educational programs for its more than 47,000 Fellows and others in this country and abroad, establishes standards of practice, disseminates medical knowledge, and provides information to the general public.

The College's Board of Regents has not established an official position on approval or disapproval of specific second surgical second opinion programs. However, we have published materials on this topic. Enclosed for your information are copies of ACS Reports on Unnecessary Surgery and on Second Surgical Opinion Programs. Also enclosed is a copy of Second Surgical Opinion Programs: A Review and Progress Report. The section titled "American College of Surgeons' Views," beginning on page 32 of that report, may be of particular interest.

The College has obtained a copy of the recent Congressional Budget Office (CBO) report estimating the budgetary impact of a mandatory second surgical opinion program for Medicare and Medicaid patients. We believe the most significant aspect of that report is the stated fact that the effects of second surgical opinion programs are largely speculative. It has been the College's view for many years that the research on second surgical opinion programs is of questionable quality at best. We also believe the costs of administering a national program -- estimated by CBO to be \$190 million -- to be considerable. Finally, the CBO report echoes our position that second surgical opinion programs are duplicative of PRO programs that are federally mandated and in operation in all 50 states.

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We call to your attention ~~the enclosed~~ article written by Steven Sieverts, vice president of Blue Cross and Blue Shield of Greater New York, which conducted several demonstration projects on second surgical opinion programs. One of the demonstrations was for Medicare Part B beneficiaries. Sieverts's view that second surgical opinion programs may increase the volume of elective operations is worth pointing out. It obviously contradicts the popular notion that these programs reduce the volume of operations. This finding appears significant in view of attempts to achieve dollar savings for the Medicare program by way of second surgical opinion programs.

We call your attention

Just as the benefits of second surgical opinion programs are open to questions, so, too, is the existence of so-called "unnecessary" surgery. In support of the existence of "unnecessary" surgery, some point to the findings of the Moss committee a decade ago. However, these findings have been discredited in the professional journals. ~~Enclosed for your information is~~ an article by Karl Pfuete, M.D., which documents the less than scientific approach taken by that committee. Furthermore, we should inform you of an editorial that appeared in the New England Journal of Medicine regarding the misuse of information that appeared in that journal by the Moss committee to show that "unnecessary" surgery exists in this country. (Source: Ingelfinger, F.J. "Misuse of Information Printed in the Journal." New England Journal of Medicine. 294:667-8. March 18, 1976.) The existence of "unnecessary" surgery in this country has not been demonstrated in either a reliable or valid manner.

We are aware that the U.S. Inspector General has recommended to the Administrator of the Health Care Financing Administration that the agency begin a mandatory second surgical opinion program for Medicare. This recommendation is based on the evaluation of programs in Massachusetts, Michigan, and Wisconsin. With respect to these programs, there are several factors that the Inspector General may have overlooked:

1. In Massachusetts, one analysis yielded a benefit-cost ratio of only \$1.11. The authors conclude that this ratio means that substantial savings are unlikely to be realized from the program.
2. In Michigan, the costs of the program under a Medicare demonstration project were as high as \$488 per second opinion.
3. In Wisconsin, the statistical techniques used in the evaluation study contained several methodological problems. As a result, the "savings" achieved were vastly overstated. Moreover, several patients sought no treatment following an initial recommendation for operation. The long-term health consequences to these patients is not known but remains a concern as an unanticipated outcome of these programs.

According to recent information from the Health Care Financing Administration (HCFA), in 1981, surgical care accounted for 32 percent of all physicians' services for which Medicare pays. Some critics claim this is too high. However, several factors need to be considered. One factor is the increase in the number of Medicare beneficiaries. Again, according to data from

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HCFA, the total population eligible for Medicare on the basis of age increased 24 percent between 1966 and 1983. Another consideration is that the general population is older. In 1984, for the first time in the history of the United States, there were more people age 65 and older than there were teenagers. As age increases so does the incidence of disease that requires surgical treatment.

Related to this are the advancements in surgical technology that have been achieved in the twenty years since the Medicare program was enacted. Today, patients can be treated surgically for problems for which very limited or no surgical intervention was available twenty years ago. In light of these factors, the 32 percent of all physicians' services that Medicare pays for surgical care seems far from excessive. Moreover, we believe that, in spite of the growth of the elderly population, Medicare beneficiaries are enjoying substantially improved health status and that this status has been achieved through allocations of Medicare's resources that do not seem unreasonable.

We understand consideration is being given to a mandatory second surgical opinion program for Medicare. We believe this would be a costly and unneeded duplication of the Peer Review Organizations (PROs) that were mandated by Public Law 97-248, the Tax Equity and Fiscal Responsibility Act, and that are now in place in all states. Indeed, Quality Objective 4 for all PROs is the reduction of so-called "unnecessary" surgery or other invasive procedures. Most of the PROs are performing preadmission certification prior to hospitalization for Medicare patients. Several PROs also have mandatory second surgical opinion programs for Medicare patients. We believe that the federal government already has acted on the issue of second surgical opinion programs.

You and your staff may be interested in the informal comments we receive from surgeons with respect to mandatory second opinion programs. Several surgeons have told us it is rare to encounter a patient who has been misdiagnosed or for whom an unneeded operation has been recommended. Differences of opinion that may arise regarding technical aspects of the operation or when to schedule the operation are usually minor and are resolved in discussions between the two surgeons. For this reason, many of the surgeons we hear from believe that the programs are superfluous and are costing insurance companies more than either the companies or the patients are gaining. A similar view has been expressed to us by both officials and staff of a major national health insurance company.


A number of surgeons also have expressed concern regarding the considerable inconvenience many patients encounter in order to comply with mandatory programs. Often this involves the need to travel several miles to obtain the second opinion, which is a problem even for those individuals who live in metropolitan areas. This is a particularly onerous requirement for those patients whose diagnoses are not in dispute and for whom operation is a necessity, not an option. Many surgeons believe the inconvenience and the anxiety that results are a major disservice to patients.

This College has carefully monitored second surgical opinion programs for several years. We remain unconvinced that these programs live up to the claims that are made about them in the throwaway journals. Indeed, there is a not insignificant amount of literature in prestigious journals that call into question the true value of the second surgical opinion programs.

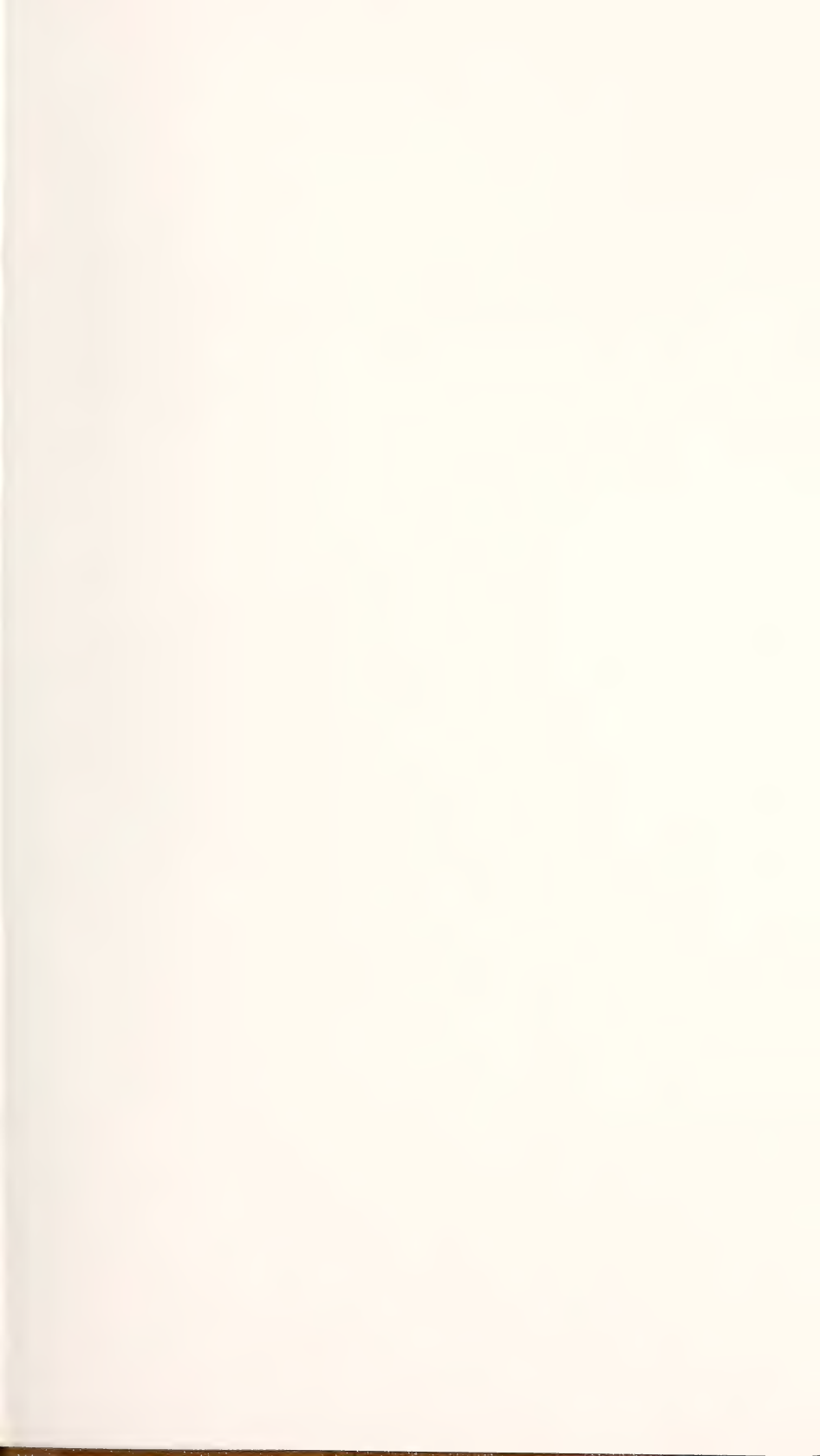
We also believe the long-term health consequences of postponing or omitting needed health care is an issue that has not been addressed adequately with respect to second surgical opinion programs.

Thank you for your consideration of our comments. We will be pleased to respond to further inquiries.

Sincerely,



C. Rollins Hanlon, M.D., F.A.C.S.

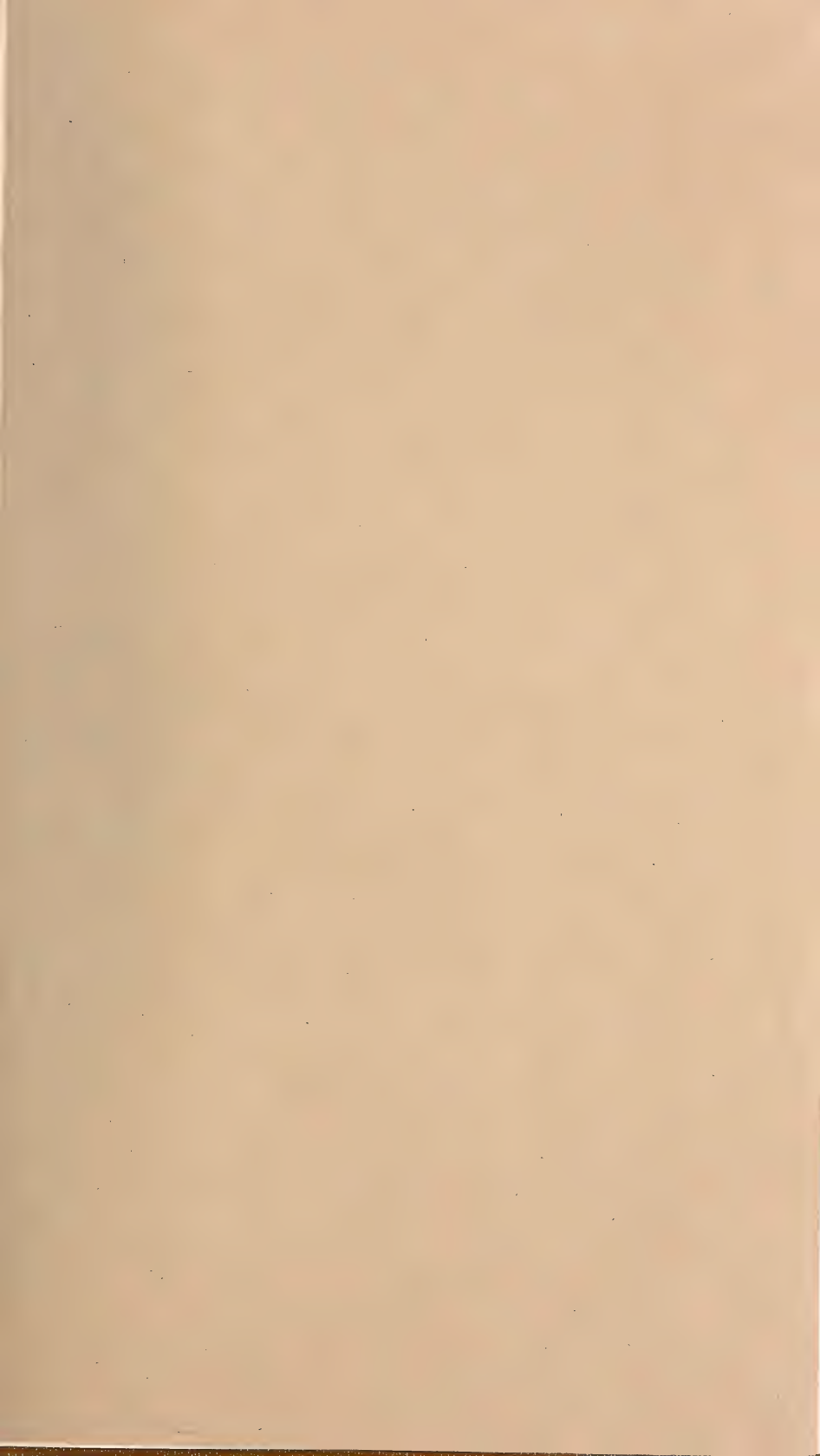












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